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George P. Smith II

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ARTICLES

All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?

*George P. Smith, II**

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During my sabbatical in 1984, I began researching and developing this Article as a Visiting Fellow at Clare Hall, Cambridge University. To the former President of the Hall, Sir Michael Stoker, I extend my thanks for his good offices that created a conducive atmosphere for contemplation and research. The innumerable kindnesses and friendship of Derek W. Bowett, the Whewell Professor of International Law and former President of Queens' College, must also be recognized. I profited from insightful dialogue with Professor Benjy F. Brooks of the University of Texas Health Science Center at Houston, who was in 1984 a Visiting Fellow at Clare Hall, and Andrew Grubb, a Fellow at Fitzwilliam College, Cambridge, concerning my present area of investigation. The resources of the Squire Law Library, the University Library, and the Radzinowicz Library of Criminology were made readily accessible thanks in full measure to the efficiency of the Librarian of the Squire, Keith J. A. McVeigh. His indefatigable spirits and high level of professionalism were a joy to behold, and I prospered from both.

When I arrived in Sydney, Australia, to take up my post as Fulbright Visiting Professor of Law and Medical Jurisprudence at the University of New South Wales under an Australian-American Fulbright Foundation Award, my good and valued friend, Dr. George G. Winterton, Chairman of the Law Faculty, had seen to it that everything was in order and ran smoothly during my stay, and for this I thank him most sincerely. The kindness and support of Professor Ivan A. Shearer, the Dean of Law Faculty and to his immediate predecessor, Professor Don Harding, are also acknowledged with pleasure. Four others in Australia must be thanked as well for their consistent encouragement, kind support, and friendship: Robert F. Brian, the Law Librarian at the New South Wales Law Faculty; Philip Bates of the Faculty of Health Administration at the University; Russell Scott, the Deputy Chairman of the New South Wales Law Reform Commission; and Justice Michael D. Kirby, CMG, President, Court of Appeal, The Supreme Court of New South Wales, especially for his vision and idealism. Finally, the generous support of the Australian-American Fulbright Foundation is sincerely

"There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy." A. Camus, *The Myth of Sisyphus*¹

"[M]ere living is not a good, but living well. Accordingly, the wise man will live as long as he ought, not as long as he can. He will mark in what place, with whom, and how he is to conduct his existence, and not the quantity, of his life. . . . It is not a question of dying earlier or later, but of dying well or ill. And dying well means escape from the danger of living ill." Seneca, *Epistula Morales*²

"In a certain state it is indecent to live longer. To go on vegetating in cowardly dependence on physicians and machinations, after the meaning of life, the right to life, has been lost, that ought to prompt a profound contempt in society . . . to die proudly when it is no longer possible to live proudly." F. Nietzsche, *Twilight of the Idols*³

"[P]erhaps we ought to make suicide respectable again. . . . Can you ever recall a coroner saying something like: 'We've heard all the evidence of how John Smith was facing literally insuperable odds and he made a courageous decision. I record a verdict of a noble death?' " B. Clark, *Whose Life Is It Anyway?*⁴

"I'm not afraid to die but I am afraid of this illness, what it's doing to me. I'm not better. I'm worse. There's never any relief from it now. Nothing but nausea and this pain. . . . Who does it benefit if I die slowly? . . .

acknowledged.

During the Summer of 1985, I was a Fellow at the Institute of Advanced Study at Indiana University in Bloomington, where I continued my research and began writing this Article. I thank, most sincerely, Dr. Roger G. Newton, the Director of the Institute and his most able Administrative Assistant, Charlene Fears, for their assistance and support during an equally pleasant stay. I would again be remiss if I did not acknowledge the encouragement and assistance which I received from Dr. David H. Smith and the Poynter Center for the Study of Ethics and American Institutions, of which he is the Director, during my very enjoyable Summer in Bloomington.

In December 1986, and again in May 1987, I was a Visiting Fellow at the American Bar Foundation in Chicago and there began to enter the final stages of work on this Article. To William L. F. Felstiner, Esquire, the Executive Director of the Foundation, I extend my large debt of gratitude for his assistance and support. The facilities of the Foundation were indispensable to me at a most critical juncture in my preparation of this Article.

Obviously, the viewpoints taken in this Article are solely my own and any errors of commission or omission are mine as well.

¹ A. CAMUS, *THE MYTH OF SISYPHUS* 3 (1940-1941); *OEUVRES COMPLETES D'ALBERT CAMUS* 135 (1983).

² Seneca, *Epistula Morales* ("On Suicide"), in *ETHICAL CHOICES* 54 (R. Beck & J. Orr eds. 1970).

³ F. Nietzsche, *Twilight of the Idols*, in *THE PORTABLE NIETZSCHE* 536 (W. Kaufman ed. & trans. 1954).

⁴ B. CLARK, *WHOSE LIFE IS IT ANYWAY?* 102 (1976).

I'm stuck — stuck in life. I don't want to be here anymore. I don't see why I can't get out." B. Rollin, Last Wish⁵

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⁵ B. ROLLIN, LAST WISH 149, 150, 170 (1985).

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INTRODUCTION

It is estimated that someone in the United States commits suicide every nineteen minutes.⁶ Yet, because of the difficulty in distinguishing

⁶ Mansfield, *Focus: Suicide*, Wash. Post, Dec. 3, 1982, at E5, col. 3.

To express the national concern over the growing problem of suicide, on October 7, 1987, House Concurrent Resolution 194 was introduced expressing, as such, "the sense of the Congress that efforts to allow people to assist others to commit suicide and efforts to promote suicide as a rational solution to certain problems should be opposed." H.R. Con. Res. 194, 100th Cong., 1st Sess. (1987).

Joseph Cardinal Bernardin of Chicago — in a letter to all congressional members — advocated passage of the Resolution and the condemnation of those efforts by right-to-die advocates to legalize acts of assisted suicide. *Bernardin Condemns Legal Assisted*

suicide from an accidental or natural death, particularly among the elderly, precise data is scarce.⁷ Indeed, most experts are of the opinion that suicide is under-reported.⁸ Under-reporting occurs primarily because attending physicians and involved families often cooperate in disguising or ignoring the less-than-obvious suicides to avoid any social stigma from attaching to the surviving relatives.⁹

Suicide may be defined "as doing something which results in one's death, either from the intention of ending one's life or the intention to bring about some other state of affairs (such as relief from pain) which one thinks it certain or highly probable can be achieved only by means of death or will produce death."¹⁰ Since death is a necessary element of suicide, reflexive descriptions of death are important to allow a full understanding of the very term, suicide. Thus, one description would be simply that one has killed herself; another would be that one has let herself be killed. Additionally, one might perform a suicide by deliberately, with premeditation, taking her own life, or by ordering an agent to accomplish the act, thereby *getting herself killed*. By falling into a pool and refusing to swim to save herself, an individual could *let herself be killed*. She could even kill herself by provoking a physical confrontation while offering little resistance and defense, thereby letting herself be killed. Thus, for a suicide to occur the deceased must kill herself, get killed, or let herself be killed.¹¹ As can be seen, suicide as a form of behavior has developed its own particular praxis.

Voluntary euthanasia has been variously described as "assisted suicide,"¹² or "within the knife's edge between suicide and murder."¹³ Sui-

Suicides, Wash. Post, Feb. 20, 1988, at C6, col. 1. However, while addressing the University of Chicago's Center for Clinical Medical Ethics in May 1988, the Cardinal expressed his opinion that on a "case by case" basis, artificially supplied food and water could be withdrawn from patients when that type of method for feeding "has become useless or burdensome." Society for the Right to Die, Newsletter 1 (Summer 1988).

⁷ Colburn, *Death by Choice: Nathan Pritikin's Suicide and The Critical Problem Affecting Aging Men*, Wash. Post Health Mag., Feb. 27, 1985, at 7.

⁸ *Id.*

⁹ *Id.*

¹⁰ Brandt, *The Rationality of Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 117, 118 (M. Battin & D. Mayo eds. 1980) [hereafter *PHILOSOPHICAL ISSUES*].

¹¹ Windt, *The Concept of Suicide*, in *PHILOSOPHICAL ISSUES*, *supra* note 10, at 39, 41.

¹² Gillon, *Suicide and Voluntary Euthanasia: Historical Perspective*, in *EUTHANASIA AND THE RIGHT TO DIE* 181 (A. Downing ed. 1969).

¹³ McClanahan, *The Patient's Right to Die: Moral and Spiritual Aspects of Euthanasia*, 38 MEM. MED. J. 303 (1963).

cide even can be self-administered euthanasia.¹⁴ Thus, the resulting conundrum queries whether a voluntary act of euthanasia should be regarded as a suicide or as a murder. Furthermore, the morality of euthanasia becomes inextricably linked to that of suicide. More specifically, if committing suicide were no longer regarded as a tendentious expression, and the very act itself were recognized as an exercise of enlightened self-determination, so too would euthanasia be similarly reclassified. These simple changes in the taxonomy of these two words would, in turn, give rise to a new attitude toward both life and death. Instead of cheapening life¹⁵ and viewing it as a casual or inconsequential occurrence, this rethinking would show a new sensitivity to the quality of life. It would not promote a passionate desire for death, but for independence, honesty, and integrity. Human disposal would not be the end sought here. Rather, the goal would be "the enhancement of human dignity by permitting each man's last act to be an exercise of his free choice between a tortured, hideous death and a painless dignified one."¹⁶

Dating from at least the seventeenth century, rational suicide has been recognized as a concept or phenomenon.¹⁷ One author suggests that the rationality of a suicidal act follows from the very rationality of the philosophy guiding the deliberations of individuals contemplating the act.¹⁸ By defining rationality as the logical means of problem solving which have proven their reliability over time, the rationality of one's philosophy may be measured not only by the degree to which it is free of mysticism, but also by the degree of self-criticism it has undergone by the decision maker.¹⁹ Accordingly, should the philosophy in question embody a set of institutionalized political or religious beliefs, any rational judgment must critically evaluate the very institutions which embody these beliefs.²⁰ While this principle is clear, its practice and application are extremely difficult to realize.²¹ Within the context

¹⁴ See G. GRISEZ & J. BOYLE, JR., *LIFE AND DEATH WITH LIBERTY AND JUSTICE* ch. 5 (1979).

¹⁵ See C. RICE, *THE VANISHING RIGHT TO LIVE* 79 (1969).

¹⁶ Giancola, *The Discontinuance of Extraordinary Medical Treatment from a Terminal Patient*, 1980 *MED. TRIAL TECH. Q.* 326, 342.

¹⁷ See Motto, *The Right to Suicide: A Psychiatrists View*, in *PHILOSOPHICAL ISSUES*, *supra* note 10, at 212, 215.

¹⁸ See *id.* It has been stated that logical suicide is often but the simple expression of philosophical pessimism. See J. MEERLOO, *SUICIDE AND MASS SUICIDE* 111 (1962).

¹⁹ See *id.*

²⁰ See *id.*

²¹ See *id.*; see also Pepper, *Can a Philosophy Make One Philosophical?*, in *ESSAYS*

of suicide, "a rational decision is the one in favor of the life course which one would prefer, comparing death with the best option open to one if he had the alternatives correctly and vividly before him in a normal frame of mind."²²

On the other hand, irrational suicide is exemplified by an individual whose despair leads her to totally abandon any serious commitment to make rational decisions on the basis of future consequences of subsequent actions.²³ Oftentimes, human commitments may require a kind of irrationality if they are in fact to be respected, e.g., unfathomable grief or mourning over the loss of a spouse or unrequited "first" loves of teenagers.²⁴

Like death, suicide as a concept is forever changing.²⁵ Although the "badness" of death is debatable,²⁶ most members of today's society would agree that suicide is bad or improper,²⁷ and that so too is euthanasia.²⁸ Life is not an amaranth, the imaginary flower that never fades. For all too many, the "benefits" of modern medicine and treatment extend the fading process with tragic withering, discoloration, and odor. The current controversy surrounding the individual's right to refuse treatment has both its genesis and its nexus in the central objection to an individual's exercise of her right of self-determination through suicide or euthanasia. Refusing necessary life-sustaining treatment has

IN SELF-DESTRUCTION 121 (F. Shneidman ed. 1967).

²² Brandt, *The Morality and Rationality of Suicide*, in *SUICIDOLOGY: CONTEMPORARY DEVELOPMENTS* ch. 12, at 391 (E. Shneidman ed. 1976) [hereafter *CONTEMPORARY DEVELOPMENTS*]. Judgments about the rationality of suicide depend on assessing alternative states of affairs and their probability (e.g., painful progression of a terminal illness). J. CHILDRESS, *WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE* 159 (1982).

In June 1980 public television presented a case documentary on Jo Roman, a New York City artist and writer, who undertook, with family support, rational suicide to avoid protracted suffering from cancer. See "*Rational Suicide*" *Raises Patient Rights Issues*, 66 A.B.A. J. 1499 (1980); Leo, *How to Commit Suicide*, *TIME*, July 7, 1980, at 49; see also J. ROMAN, *EXIT HOUSE: CHOOSING SUICIDE AS AN ALTERNATIVE* (1980).

²³ See Mayo, *Irrational Suicide*, in *PHILOSOPHICAL ISSUES*, *supra* note 10, at 133-35; see also Brandt, *supra* note 10, at 127.

²⁴ See *id.*

²⁵ See J. MEERLOO, *supra* note 18, at 111; see also Daube, *The Linguistics of Suicide*, 1 *PHIL. & PUB. AFF.* 387 (1972).

²⁶ See T. NAGEL, *MORAL QUESTIONS* 1 (1976).

²⁷ See generally *PHILOSOPHICAL ISSUES*, *supra* note 10.

²⁸ See generally Kuhse, *The Case for Active Voluntary Euthanasia*, 14 *LAW, MED. & HEALTH CARE* 145 (1986).

been declared a "form of suicide,"²⁹ and its recognition and allowance as "modern paganism."³⁰

In order to clarify the issues and to dispel the inherent confusion over this point of contention, I advocate a seemingly simple change in both the attitude and the very definition of suicide and euthanasia, which will facilitate contemporary decision making. The forces working to effect this change are found in the courts and state legislative bodies as well as in professional organizations such as the American Medical Association and the former President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. They will be explored and critically analyzed to determine whether these forums have been responsive to growing societal demands, or whether they favor unreasonable initiatives without reason or popular support.

These mechanisms will be seen as providing a framework for principled decision making that recognizes humaneness, love, and compassion, while balancing the interest of the at-risk patient against the state's interest in preserving life.³¹ In turn, these mechanisms will all conduce to a basic recognition and application of an enlightened self-determination. Questions of ethical, moral, philosophical, and religious consistency are inextricably tied to any legal analysis of the issue and are recognized and analyzed as dynamic vectors of force in the entire decision making process. Their influence oftentimes will be seen as more confusing than as unifying.

Whether a right to decline life-sustaining treatment implies an equal liberty or coordinate right to commit suicide and effect euthanasia should not be regarded as an issue of crucial concern; it is not necessary to attempt to draw a hard and fast line between suicide and a refusal of treatment decision. The major point made and the central recognition sought is that competent persons within either of these contexts should have both a moral and legal right — acting for whatever purposes — to refuse life-sustaining medical treatment.³² Furthermore, as part of a *treatment* refusal, total parenteral nutrition, feeding gastrostomies, nasogastric tubes, and all other means of providing alimentation should not be required.³³

²⁹ C. RICE, *supra* note 15, at 83.

³⁰ *Brophy v. New Eng. Sinai Hosp., Inc.*, 398 Mass. 417, 443, 497 N.E.2d 626, 640 (1986) (Nolan, J., dissenting).

³¹ See G. SMITH, *GENETICS, ETHICS AND THE LAW* 2, 8, 164 (1981).

³² See J. CHILDRESS, *supra* note 22, at 163.

³³ See Paris & McCormick, *The Catholic Tradition on the Use of Nutrients and*

Since generally most of the states have decriminalized suicide and seldom enforce prohibitions against assisting it,³⁴ under my proposal for an unfettered recognition of a right to enlightened self-determination, this shallow statutory ruse would be abolished.³⁵ Perhaps the issue of rational suicide is more tolerable or understandable if it is viewed as limiting the right to be left alone and to choose the circumstances under which treatment will be followed.³⁶

Commensurate with my primary proposal for reclassification of terms, I propose to similarly recast euthanasia so that it is definitionally and attitudinally consistent with the new principle of self-determination, and thus decriminalized. What is regarded as passive euthanasia is already widely practiced and seldom prosecuted.³⁷ If voluntary active euthanasia were not decriminalized as a consequence of the reclassification scheme propounded, then an immunity from prosecution must be allowed for those assisting a competent or incompetent individual in completing such an act of self-determination. Absent immunity from prosecution, the traditional concept of euthanasia should be allowed as an affirmative defense to a charge of murder and accepted if the participating parties acted in good faith.³⁸

The central purpose of this Article is to show that through the self-determination of an individual's life plan, not only is the full meaning of liberty acknowledged,³⁹ the individual further recognizes that the very endowment of free will forms "the basis of our right to individual freedom of action, [and] the right to carry into execution the things we freely choose to do."⁴⁰

Fluids, AMERICA, May 2, 1987, at 2.

³⁴ See Engelhardt & Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 Sw. L.J. 1003, 1019-20 (1982); Podgers, *Rational Suicide Raises Patient Rights Issue*, 66 A.B.A. J. 1499, 1500 (1980); *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1206 (1973).

³⁵ For analysis of another construct to validate suicide, see M. HEIFETZ, *THE RIGHT TO DIE* 97-98 (1975).

³⁶ See Engelhardt, *Suicide and the Cancer Patient*, 36 CA — A CANCER J. FOR CLINICIANS, Mar.-Apr. 1986, at 105.

³⁷ See Podgers, *supra* note 34, at 1501; see also G. GRISEZ & J. BOYLE, JR., *supra* note 14, at 136-38.

³⁸ See G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 339-46 (1968); Newman, *Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physicians and the State*, 3 N.Y.L. SCH. HUM. RTS. ANN. 35, 87 (1985).

³⁹ C. FRIED, *RIGHT AND WRONG* 146-47 (1978).

⁴⁰ M. ADLER, *WE HOLD THESE TRUTHS* 123 (1987).

I. THE ETIOLOGY OF SUICIDE

A. *Psychological and Historical Underpinnings*

While there are 140 possible causes of death, only four modes have been recognized: natural, accident, suicide, and homicide.⁴¹ A more meaningful and accurate classification would consider the role of the individual in her own act of self-destruction as being intentional, subintentional (when an individual plays a partial or unconscious role in promoting his own death), or unintentional.⁴²

Suicide, as a word, is thought to have originated either in Sir Thomas Browne's *Religio Medici* written in 1635 or from Walter Charleton in 1651.⁴³ "Suicidology" was used independently in the 1960s as a word to scientifically explain the study of the phenomena of suicide.⁴⁴ The term "suicide" is applied to all those cases of death that result directly or indirectly from either a positive or a negative act of the victim herself, which she knows or has reason to know will produce this desired result.⁴⁵

Though one may be reconciled to the prospect of her own death, this does not mean that she is reconciled to the prospect of death itself as an

⁴¹ CONTEMPORARY DEVELOPMENTS, *supra* note 22, at 6.

⁴² *See id.*

⁴³ *Id.* at 7. It has been suggested that the first known document dealing specifically with suicide is to be found in *Dispute Over Suicide*, an Egyptian writing thought to be from either the Middle Kingdom or earlier, around 2100 B.C. Bearing some marked similarities to the Book of Job, it focuses on a debate a man has with his soul, prompted as such, because of a series of misfortunes that have befallen him. The debate explores the values of holding onto life and seeking new pleasures or ending it and its present level of suffering. Thus, what is seen, then, is that as long as written accounts of history have been kept, suicide has been recorded. *See* D. DE CANTANZO, SUICIDE AND SELF-DAMAGING BEHAVIOUR 26 (1984).

⁴⁴ *See* CONTEMPORARY DEVELOPMENTS, *supra* note 22, at 7. *See generally* Daube, *supra* note 25, at 4.

⁴⁵ *See* E. DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY (J. Spaulding & G. Simpson trans. 1951). More specifically, Durkheim posited three types of basic suicide: altruistic, egoistic and anomic — each resulting from people's relationship to their society. *See id.* chs. 2-5. Under *altruistic* suicide, group or sub-societal customs demand suicide under certain circumstances — with *hara-kiri* and *sati* being notable examples of self-inflicted honorable death and ritual burning by a widow upon her husband's death. *See id.* *Egoistic* suicides make up the majority of all suicides in the United States and occur when an individual has limited ties with his community. *See id.* Finally, *anomic* suicides occur when an accustomed relationship between an individual and his society goes awry with the loss of a business position or the death of a close friend. *See id.*

inescapable fact of the human condition.⁴⁶ Depending upon the mores and the traditions of each society, throughout history suicide has been not only acclaimed and despised, but sought after and feared.⁴⁷

It has been postulated that suicide should be viewed as an attenuated homicide, which provides a simple and economical way of ridding society of numbers "of useless or harmful persons without social intervention."⁴⁸ The telling question, then, is put in this form: "Is it not better to let them put themselves out of the way voluntarily and quietly, than to force society to eject them from its midst by violence?"⁴⁹

Durkheim found the etiology of suicide in "abnormal psychology; social psychology; anthropology; meteorological and other cosmic factors; religion; marriage; the family; divorce; primitive rites and customs; social and economic crimes; crime, law and jurisprudence and in history, education, and occupational groups."⁵⁰ In a very real sense, then, suicide is a social phenomenon.⁵¹

In viewing suicide as simply symptomatic of individual psychopathology together with social disorganization, over time, its philosophical underpinnings were neglected for legal and scientific analysis.⁵² Today, with respect to both the theory and application of suicide, scholars are now recognizing the inextricable relationship that exists among law, philosophy, and medical science.⁵³ This recognition itself becomes a form of suicide, validating voluntary euthanasia as an acceptable alternative to intolerable pain, suffering, and economic depletion.⁵⁴

In reality, the hard questions of suicide focus on death control and management. Ultimately, any analysis of the morality, the rationality and the right to die must take in account a plethora of complex medical

⁴⁶ A. TOYNBEE, *MAN'S CONCERN WITH DEATH* 264 (1968).

⁴⁷ M. HEIFETZ, *supra* note 35, at 73.

⁴⁸ E. DURKHEIM, *supra* note 45, at 341.

⁴⁹ *Id.*

⁵⁰ *Id.* at 13. The most accepted psychoanalytic view of suicide is that it is a form of displacement or a desire to kill someone who has thwarted the individual suicidee. *Id.* at 24. Through this act of displacement, the act of suicide is turned back on the suicide victim herself. *Id.* Stated technically, the suicide murders the intrajected object and thereby expiates her guilt for wanting to murder the object. *Id.* Accordingly, the ego is satisfied and the superego mollified through self-murder. *Id.*

Today, however, suicidologists believe that hostility, frustrated dependency, hopelessness, and helplessness also have considerable significance in promoting suicide. See CONTEMPORARY DEVELOPMENTS, *supra* note 22, at 10.

⁵¹ E. DURKHEIM, *supra* note 45, at 326.

⁵² See PHILOSOPHICAL ISSUES, *supra* note 10.

⁵³ See *id.*

⁵⁴ See *id.*

and nonmedical considerations. Such considerations would include the competent and the incompetent individual's refusal of lifesaving medical treatment, informed consent to potentially lethal experimental studies and fatal organ donations, as well as the destructive behaviors of alcohol drinking and cigarette smoking.⁵⁵ Inevitably, autonomy and self-determination become watchwords for death with dignity.

No passage within the Old Testament clearly propounds an explicit view of the ancient Judaic view on suicide.⁵⁶ In fact, the Old Testament reports only eight incidents that might properly be considered suicide.⁵⁷ As in the New Testament, the Old Testament does not contain any explicit prohibition against suicide.⁵⁸ Although cultural prohibitions may have restrained suicides with respect to the Hebrews, the infrequency of suicides may be a direct result of the centrality of positivism within the religious tenets which placed not only a high value on life itself, but acknowledged God's special providential commitment to them as a people.⁵⁹

Neither the Greek nor Roman laws uniquely addressed the issue of suicide — except when the acts of either a slave or soldier led to suicide.⁶⁰ The penalties for such acts were the forfeiture of all personalty previously owned by the suicidee and the confiscation of his estate, thereby preventing the passage of the estate to the heirs.⁶¹ With respect to Greco-Roman physicians, their assistance to suicidees was a commonplace activity and regarded as outside the scope and interest of the law.⁶² Indeed, the Platonists, Cynics and Stoics considered the act of

⁵⁵ See *id.*

⁵⁶ A. ALVAREZ, *THE SAVAGE GOD* 41-63 (1971); Farberow, *Cultural History of Suicide*, in *SUICIDE IN DIFFERENT CULTURES* 1, 3-4 (N. Farberow ed. 1975); Hankoff, *Judaic Origins of the Suicide Prohibitions*, in *SUICIDE THEORY AND CLINICAL ASPECTS* 1 (L. Hankoff & B. Einsidler eds. 1979); Smart, *Death in the Judaeo-Christian Tradition*, in A. TOYNBEE, *supra* note 46, at 116 *passim*.

⁵⁷ See *supra* note 56.

⁵⁸ See *Judges* 9:54, 16:30; 1 *Samuel* 31:4; 2 *Samuel* 17:23; 1 *Kings* 16:18; 2 *Maccabees* 7:1-42, 10:113, 14:41.

⁵⁹ See D. DE CANTANZO, *supra* note 43, at 27; N. ST. JOHN-STEVAS, *THE RIGHT TO LIFE* 58 (1964). Perhaps the most notable exception to this position was in 73 A.D. at Massada when some 960 Jews committed acts of mass suicide to avoid an inevitable capture by victorious Romans. See D. DE CANTANZO, *supra* note 43, at 27; see also Hankoff, *supra* note 56.

⁶⁰ See Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots*, *HASTINGS CENTER REP.*, Aug. 1978, at 23.

⁶¹ Farberow, *supra* note 56, at 1, 6.

⁶² See Amundsen, *supra* note 60; see also Daube, *supra* note 25.

suicide as "an honorable alternative to hopeless illness."⁶³

Open toleration of suicide may have commenced with the Greeks,⁶⁴ who tolerated the act when it was undertaken for nobility of purpose,⁶⁵ such as an expression of grief, high patriotic principle or to avoid dishonor.⁶⁶ Moderation and high principle were the keys to this acceptant view; wantonness was not condoned.⁶⁷ The "acceptance" of suicide as a rational act came with the Roman assimilation of Greek Stoic philosophy, which made suicide the most reasonable and desirable of all ways to end life.⁶⁸ Both the Stoics and the Epicureans claimed to be as indifferent to death as to life.⁶⁹ For the Epicureans, the focus was pleasure; whatever promoted pleasure was good and whatever produced pain was evil.⁷⁰ For the Stoics, the focus was a vague, but dignified ideal of life in accordance with nature.⁷¹ When it no longer seemed in accord, then death came as a rational choice befitting a rational nature.⁷²

The Greek Stoics embraced a rational attitude toward suicide that conformed to their ideal of life in accordance with nature. The advanced Stoicism of the later Roman Empire internalized these beliefs.⁷³ Ultimately, the dilemma drifted from the question of whether or not one should kill herself, but how to do so with the greatest dignity, bravery and style.⁷⁴ Stated otherwise, the Greeks divested suicide of all primitive horrors and gradually began to discuss the subject more or less in an objective unemotional manner.⁷⁵ The Romans, however, reinvested it with emotion — but in doing so, turned the emotions upside down.⁷⁶ Suicide was no longer morally evil; to the contrary, one's man-

⁶³ Amundsen, *supra* note 60, at 27. Shintoism, Buddhism and Hinduism allow suicide in cases of incurable disease; Islamic and Judaic religions condemn it, and Catholicism opposes it. See M. HEIFETZ, *supra* note 35, at 78.

⁶⁴ PHILOSOPHICAL ISSUES, *supra* note 10, at 2.

⁶⁵ See W. DURANT, *THE STORY OF CIVILIZATION: THE LIFE OF GREECE 655-57* (1939).

⁶⁶ See A. ALVAREZ, *supra* note 56, at 58-67.

⁶⁷ *Id.* at 18.

⁶⁸ See W. DURANT, *supra* note 65, at 657.

⁶⁹ See G. WILLIAMS, *supra* note 38, at 252.

⁷⁰ See DeLacy, *Epicureanism and the Epicurean School*, 3 *ENCYCLOPEDIA OF PHILOSOPHY* 2 (P. Edwards ed. 1967).

⁷¹ See Hallie, *Stoicism*, 8 *ENCYCLOPEDIA OF PHILOSOPHY*, *supra* note 70, at 19-22.

⁷² See *id.*

⁷³ See G. WILLIAMS, *supra* note 38, at 21; see also Hudson, *Suicide: Madness or the Noble Roman Way?*, *THE PHAROS*, Fall 1952, at 45.

⁷⁴ See *id.*

⁷⁵ See *id.*

⁷⁶ See *id.*

ner of going became but a practical test of excellence and of virtue.⁷⁷ Indeed, the manner in which a Roman died was viewed as the measure of ultimate value of life.⁷⁸

The early Christians also showed an indifference to death, but from a different perspective.⁷⁹ Since life itself was unimportant, and because the world only tempted one to sin, death was a welcome blessing. Stated otherwise, the more the Church expressed its view that the world was full of sin and temptation and that humans wait only on earth until death releases them to heavenly glory, the more irresistible the temptation to suicide became.⁸⁰

Because of a growing inability to distinguish approved and glorified martyrdom from ignominious acts of suicide, St. Augustine (354-430 A.D.) condemned suicide even though the Stoics condoned such acts for those Christian women who had been violated by invading barbarians.⁸¹ Augustine considered self-imposed death from a number of perspectives and concluded that the act was sinful because it violated the Sixth Commandment: namely, "Thou shall not kill."⁸² He suggested only two circumstances when self-imposed death would be tolerated: (1) when performed validly by the state, as in war or as an exercise of

⁷⁷ See *id.*

⁷⁸ See G. WILLIAMS, *supra* note 38, at 68.

⁷⁹ See D. PORTWOOD, COMMON SENSE SUICIDE 22 (1978); G. WILLIAMS, *supra* note 38, at 254-55.

⁸⁰ See M. HEIFETZ, *supra* note 35, at 77. Actually, in 452 A.D., the Council of Arles declared suicide a crime and concluded that it was caused "by a diabolically inspired fury." E. DURKHEIM, *supra* note 45, at 327.

It was not until 563 A.D., however, that a penal sanction was first imposed at the Council of Prague. *Id.* Accordingly, the victims of suicide were disallowed a burial mass "and the singing of psalms" as their bodies were buried. *Id.* Civil penalties were subsequently added. *Id.*

In tenth century England, suicides were associated with robbers, assassins, and all other criminals, and it was customary to drag the body of the person who committed suicide — pierced with a stick crossways — through the streets and bury it on a highway. *Id.* at 328. In Zurich, if one who committed suicide stabbed herself, a fragment of the wood in which the knife was fixed was driven into the body near the head. *Id.* Similarly, if she had drowned herself, she was then buried under five feet of water in the sand. *Id.*

⁸¹ P. LANDSBERG & L. LANDSBERG, THE EXPERIENCE OF DEATH AND THE MODEL PROBLEM OF SUICIDES 77 *passim* (1953).

⁸² In Book I of *The City of God*, Augustine stated: "It is not without significance, that in no passage of the holy canonical books there can be found either divine precept or permission to take away our own life, whether for the sake of entering the enjoyment of immortality, or of shunning, or ridding ourselves of anything whatsoever." W. OATES, BASIC WRITINGS OF ST. AUGUSTINE 27 (1948).

capital punishment; and (2) when intimidated by God, as with the death of certain individuals such as Abraham and Samson.⁸³ However, no authority reposed within the individual to take her own life.⁸⁴

In the Middle Ages, St. Thomas Aquinas followed the path of St. Augustine and proclaimed that self-imposed death must be regarded as sinful.⁸⁵ Following the Renaissance and Reformation, the early 1600s saw the erosion of the unyielding opposition to suicide. This turn of events was sparked primarily by the publication of *The Anatomy of Melancholy* in 1621 by Robert Burton and *Biathantos* in 1646 by John Donne.⁸⁶

By the eighteenth century, both opponents and defenders of suicide found themselves still philosophically adrift without any distinct position regarding suicide.⁸⁷ It remained for David Hume and Immanuel Kant to polarize thought by their analyses of this issue. It is far beyond the scope of this Article and this brief historical overview to probe the underpinnings of these two men's philosophies. Suffice it to state succinctly that, as an empiricist, Hume laid the foundation of morality in a "natural sentiment that distinguishes the good and the bad."⁸⁸ Morality could not be founded on God because verification of God's existence was lacking.⁸⁹ If an obligation undertaken involved the promotion or endurance of great suffering, society is not entitled to extract it from the individual herself.⁹⁰ Accordingly, if one's life promoted no type of mutual benefit for either the individual or society, the moral imperative to continue that life would fail.⁹¹

Kant tied the foundation of morality to the nature of the human person.⁹² Although he espoused self-sacrifice, observing that it was better "to sacrifice one's life rather than one's morality," he would not have

⁸³ See *id.* at 28, 32-33.

⁸⁴ See *id.*

⁸⁵ See T. AQUINAS, *SUMMA THEOLOGICA* 1470 (Dominican ed. 1947). The reason for the sinfulness of the act was tied to three arguments: it contradicted the natural inclination toward self-preservation and charity; it inflicted injury upon the particular community wherein the suicidee lived; and it violated the exercise of God's rights as Creator over humans' destiny. *Id.*

⁸⁶ See Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 31 *passim* (1985).

⁸⁷ *Id.* at 33.

⁸⁸ *Id.* at 34.

⁸⁹ *Id.*

⁹⁰ *Id.* at 35.

⁹¹ *Id.*

⁹² *Id.* at 36.

this idea confused with suicide.⁹³ Committing suicide was an immoral act because:

If he destroys himself in order to escape from painful circumstances, he uses a person merely as a means to maintain a tolerable condition up to the end of life. But a man is not a thing. . . .⁹⁴ To destroy the subject of morality in his own person is tantamount to obliterating from the world, as far as he can, the very existence of morality itself.⁹⁵

In 1854 the common law courts of England first recognized the criminality of suicide.⁹⁶ Although no clear answer accounts for the delay for this action, the courts may have simply sought to enrich the coffers of the treasury, rather than to structure a deliberate penal policy against such acts.⁹⁷

In the mid-1700s in England, the punishment for suicide was forfeiture and confiscation of the victim's personal property, while all real property passed to the heirs of the decedent's estate.⁹⁸ By 1870, the Forfeiture Act⁹⁹ abolished all forfeitures for suicides.¹⁰⁰ Finally, the Suicide Act of 1961¹⁰¹ decriminalized acts of suicide and attempted suicides, although complicity in another's suicide remains a felony.¹⁰²

From the colonial period through the 1970s, American society clearly opposed suicide.¹⁰³ It is debatable whether the American colonies adopted *in toto* England's common-law criminalization of suicide.¹⁰⁴ However, most commentators would agree that by the nineteenth century suicide in America was no longer viewed as a criminal offense.¹⁰⁵ Today, a majority of the states have statutes that prohibit assisting sui-

⁹³ *Id.* at 37 (quoting Kant, *Metaphysics of Morals*, in METAPHYSICAL PRINCIPLES OF VIRTUES 83 (J. Ellington trans. 1964)).

⁹⁴ *Id.* (quoting Kant, *supra* note 93, at 83-84).

⁹⁵ *Id.* (quoting I. KANT, LECTURES ON ETHICS 152 (L. Infield trans. 1963)).

⁹⁶ See *Regina v. Doody*, 6 Cox Crim. Cas. 463 (1854); see also *Regina v. Man*, 2 K.B. 107 (1914); *Regina v. Burgess*, 169 Eng. Rep. 1387 (1862).

⁹⁷ See G. WILLIAMS, *supra* note 38, at ch. 7.

⁹⁸ See 4 W. BLACKSTONE, COMMENTARIES *189, *190. See generally Silving, *Suicide and Law*, in CLUES TO SUICIDE ch. 9 (E. Shneidman & N. Farberow eds. 1957).

⁹⁹ The Forfeiture Act of 1870, 33 & 34 Vict., ch. 23.

¹⁰⁰ See *id.*

¹⁰¹ The Suicide Act of 1961, 9 & 10 Eliz. 2, ch. 60.

¹⁰² See *id.*

¹⁰³ See Marzen, O'Dowd, Crone & Balch, *supra* note 86, at 100.

¹⁰⁴ See *id.* at 63-64.

¹⁰⁵ See *id.* at 98-99. However, judicial precedent in Alabama, Oregon, and South Carolina holds suicide to be a crime. See *Southern Life & Health Ins. Co. v. Wynn*, 29 Ala. App. 209, 194 So. 421 (1940); *Wycoff v. Mutual Life Ins. Co.*, 173 Or. 592, 147 P.2d 227 (1944); *State v. Levell*, 34 S.C. 120, 13 S.E. 319 (1891).

cide.¹⁰⁶ Three other states hold an individual who assists a suicide as a principal to murder.¹⁰⁷ Relying upon the common law of crimes,¹⁰⁸ both Maryland¹⁰⁹ and Massachusetts¹¹⁰ would probably also penalize assisting suicide. It is less certain whether Alabama,¹¹¹ the District of Columbia,¹¹² West Virginia,¹¹³ Virginia¹¹⁴ and Tennessee,¹¹⁵ would follow suit. While Hawaii¹¹⁶ and Indiana¹¹⁷ treat acts of causing suicide as punishable offenses, they do not prohibit the act of assisting it. Nine other states have no such prohibitions.¹¹⁸ Yet, prosecutions for either aiding or abetting suicide are quite rare.¹¹⁹

¹⁰⁶ See ALASKA STAT. §§ 11.41.100-(a) (2), 11.41.120 (a) (2) (1983); ARIZ. REV. STAT. ANN. § 13-1103 (A) (3) (Supp. 1985); ARK. STAT. ANN. § 41-1504 (1) (1977); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. § 18-3-104 (1) (b) (1978); CONN. GEN. STAT. ANN. § 53a-56 (a) (2) (West 1985); DEL. CODE ANN. tit. 11, § 645 (1979); FLA. STAT. ANN. § 782.08 (West 1976); KAN. STAT. ANN. § 21-3406 (1981); ME. REV. STAT. ANN. tit. 17A, § 204 comment (1983); MINN. STAT. ANN. § 609.215 (West 1987); MISS. CODE ANN. § 97-3-49 (1972); MONT. CODE ANN. § 45-5-105 (1986); NEB. REV. STAT. § 28-307 (1985); N.J. STAT. ANN. § 2C:11-6 (West 1982); N.M. STAT. ANN. § 40A-2-5 (1964); N.Y. PENAL LAW §§ 120.35, 125.15 (3) (McKinney 1987); OKLA. STAT. ANN. tit. 21 § 813 (West 1983); OR. REV. STAT. §§ 163.117, 163.125 (1) (b) (1985); 18 PA. CONS. STAT. ANN. § 2505 (Purdon Supp. 1988); S.C. CODE ANN. § 16-1-10 (Law. Co-op 1976); S.D. CODIFIED LAWS ANN. § 22-16-37 (1988); TEX. PENAL CODE ANN. § 22.08 (Vernon 1974); WASH. REV. CODE ANN. §§ 9A.36-060 (1977); WIS. STAT. ANN. § 940.12 (West 1982); see also Englehardt & Malloy, *supra* note 34, at 1019 nn.69-70 (citing various case authorities holding similarly to statutes cited *supra*).

¹⁰⁷ See *Burnett v. People*, 204 Ill. 208, 211, 68 N.E. 505, 508 (1903); *People v. Roberts*, 211 Mich. 187, 198, 178 N.W. 690, 693 (1920); *Blackburn v. State*, 23 Ohio St. 146, 162-63 (1870).

¹⁰⁸ See Note, *Criminal Liability of Participants in Suicide: State v. Williams*, 5 Md. L. Rev. 324 (1941).

¹⁰⁹ See *id.*

¹¹⁰ See *Commonwealth v. Dennis*, 105 Mass. 162 (1870).

¹¹¹ See Brenner, *Undue Influence in the Criminal Law: A Proposed Analysis of the Criminal Offense of Causing Suicide*, 47 ALB. L. REV. 62 (1982).

¹¹² See D.C. CODE ANN. § 6-2428 (Supp. 1984).

¹¹³ See W. VA. CODE § 16-30-8 (a) (1984).

¹¹⁴ See A. SCOTT, *CRIMINAL LAWS IN COLONIAL VIRGINIA* 27 (1930).

¹¹⁵ See, e.g., *State v. Alley*, 594 S.W.2d 381 (Tenn. 1980).

¹¹⁶ See HAW. REV. STAT. § 707-702 (1) (b) (1975).

¹¹⁷ See IND. CODE ANN. § 35-42-1-2 (West 1978).

¹¹⁸ See *State v. Campbell*, 217 Iowa 848, 251 N.W. 717 (1933); *Oubre v. Mutual Life Ins. Co. of New York*, 21 So. 2d 191 (La. Ct. App. 1945); KY. REV. STAT. ANN. § 500.020 (Michie/Bobbs-Merrill 1985); NEV. REV. STAT. §§ 458, 667 (1967); N.C. GEN. STAT. § 14-17.1 (1981); 1973 N.D. LAWS 215, 300; UTAH CODE ANN. § 76-1-105 (1978); WYO. STAT. § 6-1-102 (Supp. 1985).

¹¹⁹ See *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*,

In summary, many American jurisdictions punish neither acts of suicide nor assistance thereto. Yet, other jurisdictions criminalize attempted suicide. Interestingly, since the Nation's founding, the majority of jurisdictions have imposed no criminal sanction upon individuals who have successfully or unsuccessfully undertaken to end their lives.¹²⁰ Despite the divergence of responses, however, America reflects common Western attitudes toward death.

Philippe Aries, the noted French social historian, identified and charted three phases in the development of Western attitudes toward death.¹²¹ In the Middle Ages, death was viewed as an unexceptional, impersonal event. In essence, the Christian belief in immortality led the community to accept death with a simple resignation.¹²² The phrase '*et moriemur*' — and we shall die — characterized this attitude. At the turn of the twentieth century, the recognition of the individual's importance led to a much more personal conception of death. Thus, people insisted upon participating in their own death because they saw it as a truly exceptional moment in time; the moment that gave their own individuality a definite, observable form.¹²³ The logic offered here was that if one were to be master of her own life, then obviously she must be master of her own death, '*la mort de soi*.' Curiously, in the traditional deathbed scene of this period, the dying person became the principal character presiding over the proceedings, while the onlookers treated the event in a matter-of-fact manner. Accordingly, mourning tended to be quite conventional and perfunctory.¹²⁴

By the seventeenth century, the dying person shared her death with her family and friends. All concerned parties participated in the decision making process of dying, whereas in the past, these matters were solely the concern of the afflicted person.¹²⁵ Interestingly, by the middle of the eighteenth century, a new attitude towards death had arisen: '*la*

supra note 29, at 1206 (1973); see also W. LAFAYE & A. SCOTT, JR., CRIMINAL LAW 569 (1972).

¹²⁰ See Marzen, O'Dowd, Crone & Balch, *supra* note 86, at 98; *id.* at 148-242 (giving comprehensive case and statutory analysis of suicide laws in United States); see also Engelhardt & Malloy, *supra* note 29, at 1019-20; Schulman, *Suicide and Suicide Prevention: A Legal Analysis*, 54 A.B.A. J. 855, 858-60 (1968); Shaffer, *Legal Views of Suicide*, in CONTEMPORARY DEVELOPMENTS, *supra* note 22, ch. 13.

¹²¹ See P. ARIES, WESTERN ATTITUDES TOWARDS DEATH: FROM THE MIDDLE AGES TO PRESENT ch. 1 (P. Ranum trans. 1974).

¹²² See *id.* ch. 2.

¹²³ See *id.*

¹²⁴ See *id.*

¹²⁵ See *id.* chs. 3, 4.

mort de ton' — or thy death. Thus, the onlookers in a deathbed scene now assumed a greater responsibility. They were expected to observe *and* act upon the dying person's wishes. More importantly, they were expected to preserve her memory.¹²⁶ The hope of living forever in the memory of posterity took form in the architecture and iconography of tombs with cemeteries more or less becoming museums.¹²⁷

Toynbee suggests that Western attitudes toward death have been changing over the last 300 years as a consequence of the "contemporary progressive recession . . . of the beliefs in the tenets of Christianity."¹²⁸ An honest belief in Christian doctrine is obviously something more than a mere intellectual acknowledgement of a set of theological propositions; it involves an *auto de fe* which commits the believer to action not only on a moral and spiritual plane, but on an intellectual one as well. In a word, "It commits him . . . to the Christian attitude towards death."¹²⁹

In the West, particularly in the United States, the word "death" has until recently been regarded as an almost unmentionable word.¹³⁰ Indeed, individuals have attempted to defy death by utilizing a deep-freeze process known as cryonic suspension designed to suspend the bodily processes at "death" until resuscitation can be undertaken at a later time.¹³¹ For all these shifts in attitudes, death is still regarded as "un-American," as evidenced by the preference of referring to death as "passing on" or "passing away."¹³² Tragically, there is still a marked reluctance to advise a dying person that she is dying.¹³³ The exaggerated and almost simple-minded insistence on physical continuance by all necessary means not only ignores the qualitative condition in which life is pursued, but also is childish and narcissistic. Such an obsession distracts "the soul's natural quest. It is a distraction from the duty to master the fine art of living well, which requires rising above concern

¹²⁶ See C. BECKER, *THE HEAVENLY CITY OF THE PHILOSOPHERS* 148-49 (1932).

¹²⁷ See *id.*; see also A. ALVAREZ, *supra* note 56, at 41 *passim* (observing history of death practices).

¹²⁸ Toynbee, *Changing Attitudes Towards Death in the Modern Western World*, in A. TOYNBEE, *supra* note 46, at 122.

¹²⁹ *Id.*

¹³⁰ *Id.* at 131. See generally J. MITFORD, *THE AMERICAN WAY OF DEATH* (1963).

¹³¹ See G. SMITH, *MEDICAL-LEGAL ASPECTS OF CRYONICS: PROSPECTS FOR IMMORTALITY* (1983); Smith, *Cryonic Suspension and the Law*, 17 *OMEGA* 1 (1986-87); Smith, *The Iceperson Cometh: Cryonics and the Law*, 1 *J. CONTEMP. HEALTH ISSUES* 23 (1983).

¹³² Toynbee, *supra* note 128, at 131.

¹³³ *Id.* See generally SOCIETY FOR THE RIGHT TO DIE, *THE PHYSICIANS AND THE HOPELESSLY ILL PATIENT* 5 *passim* (1985).

for mere bodily continuance."¹³⁴ Acceptance of death should be viewed "as inherent to life and happiness" and "belongs to normal life."¹³⁵

B. Contemporary Causes and Concerns

Suicide has become a common fact of life. Many explanations have been offered in an effort to understand it. In 1840 some commentators believed that the increased numbers of suicides were due in large part to socialism.¹³⁶ To prove this point, the sudden increases in suicides were shown to have coincided with the publication of Tom Paine's *Age of Reason*.¹³⁷ Other causative factors, including "atmospherical moisture" and "masturbation," were listed as well.¹³⁸ Indeed, masturbation was viewed as "a certain secret vice which . . . [was] practiced to an enormous extent in our public schools."¹³⁹ Two major cures designed to stem suicidal urges were cold showers and laxatives.¹⁴⁰ Another popular belief was that suicide was an act undertaken largely by young lovers.¹⁴¹ Others sought to explain it away by viewing it as a "national habit" which descended upon some people like a plague.¹⁴² President Dwight Eisenhower even went so far as to express his belief that the high suicide rate in Sweden was an uncontroverted example of the ravages of uncontrolled social welfare.¹⁴³

Perhaps the most common denominator of suicides is loneliness—a motive arising from marital discord, sickness, unrequited love affairs, and from social factors such as unemployment, divorce, widowhood and imprisonment.¹⁴⁴ Loneliness and interpersonal conflicts are properly considered as motives for suicides, not as causes. The causes of suicide are understood as "the biophysical driving forces, which often do not

¹³⁴ Will, *In Praise of Mortality*, in *THE MORNING AFTER: AMERICAN SUCCESSES AND EXCESSES* 410, 411-12 (G. Will ed. 1986).

¹³⁵ J. MEERLOO, *supra* note 18, at 111.

¹³⁶ See D. MAGUIRE, *DEATH BY CHOICE* 216, 217 (1975).

¹³⁷ See *id.*

¹³⁸ See *id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at 217.

¹⁴² See *id.*

¹⁴³ See *id.*

¹⁴⁴ See Fox, *The Recent Decline of Suicide in Britain: The Role of the Samaritan Suicide Prevention Movement in Britain*, in *CONTEMPORARY DEVELOPMENTS*, *supra* note 22, at 499, 501-02. In "The Dialogue of a Misanthrope with His Own Soul" or, "Dispute over Suicide," discovered in ancient Egypt and commonly regarded as the first known discourse on suicide, social isolation and loneliness emerge as principal reasons for the author of that manuscript to contemplate suicide. *Id.* at 500-01.

even rise to the consciousness of the individual and thus cannot constitute motives, but which are related to race, age, sex, work and social status."¹⁴⁵ Whatever may be classified as motives and causes within the taxonomy of suicidal behavior, those who seek to complete the act itself often complain that either their lives no longer have meaning or they are no longer "worth living."¹⁴⁶ They no longer have a sense of self-mastery in their lives because of failures in interpersonal relations and economic pursuits.¹⁴⁷

Another theory suggests that one can inherit certain hereditary vulnerabilities toward suicide.¹⁴⁸ Sociobiologists and behavioral ecologists in fact stress human biological adaption as the determinative factor in understanding and dealing with the issues of suicide. Accordingly, this perspective simply subsumes the other theories advanced by sociology, psychodynamic models, anthropology, cognition and learning, and physiology.¹⁴⁹

While no common denominator may explain suicide as a conscious rational process,¹⁵⁰ Durkheim has implied that when individuals consider suicide, they make a "conscious-rational choice" drawn from and built upon motives actually founded in reality.¹⁵¹ Interestingly, at one time or other the vast majority of all members of society has "played" with the idea of committing suicide.¹⁵² This fact is consistent with Freud's *Destruo* or death drive which he found in people:¹⁵³ "Man's inner destructibility is, like every instinctual tendency, rooted in both the primary drive to live and in its opposite — the tendency to return to the inorganic matrix."¹⁵⁴

¹⁴⁵ *Id.* at 502.

¹⁴⁶ *Id.*; see also *AIDS Patients Found at Higher Risk of Suicide: Treatment Urged for Depression, Delirium Associated with Illness*, Wash. Post, Mar. 4, 1988, at A5, col. 1.

¹⁴⁷ See Peck, *Towards a Theory of Suicide: The Case for Modern Fatalism* 11 OMEGA 1, 11 (1980-1981). A cross-cultural illustration is Japan, where the ritual of *oyako-shinju* — or parent-child suicide — is recognized as an honorable escape from pressing family problems. TIME, June 11, 1983, at 51. In 1982 Japan recorded about four hundred cases of family suicide. *Id.*

¹⁴⁸ See R. LIFTON, *THE BROKEN CONNECTION* 256-57 (1979).

¹⁴⁹ See D. DE CANTANZO, *supra* note 43, at 158-59 *passim*.

¹⁵⁰ See E. DURKHEIM, *supra* note 45, at 10; J. JACOBS, *ADOLESCENT SUICIDE* ch. 1 (1970).

¹⁵¹ E. DURKHEIM, *supra* note 45, at 136.

¹⁵² J. MEERLOO, *supra* note 18, at 65.

¹⁵³ See *id.* at 2, 20.

¹⁵⁴ *Id.* at 21. The use of hunger strikes (very often ending in death) as a form of social and political bargaining power has drawn more attention as a consequence of

In the United States, the two most common disorders found afflicting suicide victims are depression and chronic alcoholism.¹⁵⁵ Physicians often neglect to diagnose a patient's depression and alcoholism. Moreover, when patients are properly diagnosed, they are not treated vigorously by either actual hospitalization, drug therapy, or electroconvulsive therapy.¹⁵⁶ With improved methods of treatment, heightened recognition of the symptomology of suicide, and the growth of suicide-prevention services, the incidence of suicide may eventually be curtailed.¹⁵⁷

Since most Americans choosing suicide elect to complete the act by using handguns, restricting the use of handgun availability would cause fewer Americans to commit suicide.¹⁵⁸ Interestingly, lower suicide rates exist in those states where there are strict gun control laws.¹⁵⁹

1. The Elderly

The elderly who commit suicide are not dramatically different from younger teenagers who commit suicide. In each case, the loss of health or reverses in economic affairs promotes an inescapable sense of hopelessness.¹⁶⁰ The principal difference between the age groups is that the elderly succeed in their mission more often than others. Studies indicate

Northern Ireland's volatile situations. The Roman Catholic Church is increasingly reluctant to judge someone who commits suicide in this manner and to deny them a proper church burial. See Briggs, *Catholic Church Endeavors to Put Hunger Strikes in Perspective*, N.Y. Times, June 8, 1981, at B1, col. 1.

¹⁵⁵ See Hudgens, *Preventing Suicide*, 308 NEW ENG. J. MED. 897 (1983); see also E. ROBBINS, *THE FINAL MONTHS* 12 (1981).

In a clinical analysis of suicidal motivations in over 1,000 suicide cases, researchers found that: (1) nearly 10% of those committing suicide were not consciously motivated, but instead they were deranged or alcoholic individuals who acted impulsively; (2) 25% of people were regarded as mentally unstable; (3) 40% of these individuals impulsively acted based on strong emotion (pain, distress, shame, defeat), yet they were not viewed as psychotic; and 25% of those committing suicide undertook suicide after thoroughly considering the pros and cons of life and death. See J. MEERLOO, *supra* note 18, at 25. For examples of other statistical assertions, see Dorpat, Anderson & Ripley, *The Relationship of Physical Illness to Suicide*, in *SUICIDAL BEHAVIORS: DIAGNOSIS AND MANAGEMENT* 209 (H. Resnick ed. 1968) [hereafter *DIAGNOSIS AND MANAGEMENT*]; Shneidman, *Orientations Toward Death: A Vital Aspect of the Study of Lives*, in *DIAGNOSIS AND MANAGEMENT*, *supra*, at 21.

¹⁵⁶ See Hudgens, *supra* note 155.

¹⁵⁷ See *id.*

¹⁵⁸ See Boyd, *The Increasing Rate of Suicide by Firearm*, 308 NEW ENG. J. MED. 872 (1983).

¹⁵⁹ Hudgens, *supra* note 155, at 898.

¹⁶⁰ See Streitfeld, *Suicide in Pairs: Together in Final Anguish*, Wash. Post, Mar. 5, 1987, at B5, col. 1.

a ratio of attempts to completions among fifteen to twenty-four year olds as high as 200 to 1, while in the over sixty-five year old age groups, the ratio is 4 to 1.¹⁶¹

For the older and socially isolated, the intent to die is more genuine and the choice of methods to effect that end is more lethal.¹⁶² Normally, with dual suicides or murder-suicides, three common scenarios have been identified.¹⁶³ The first scenario proffers the explanation: "You're dying, and I love you too much to exist without you."¹⁶⁴ In the second, a gravely ill, dying wife asks her husband to kill her, since she is unable to carry out the act herself. Fearing a conviction, the husband may then take his own life as well.¹⁶⁵ The third scenario grows out of the inadvertent death of one of the spouses.¹⁶⁶ For example, a distressed or physically ill husband may murder his wife to spare her from either losing him or being abandoned after he has departed. In effect, he is saying that: "[L]ife will be much worse for you when I die, so I'm going to spare you from that pain by killing you now. After I've done that, I can kill myself."¹⁶⁷

The number of these dual suicides may be reduced by redoubling efforts to assure the elderly of a meaningful societal role after they have retired or after the other spouse dies.¹⁶⁸ The heavy commitment in economic support necessary to make these assurances makes their implementation questionable. Indeed, today's health care expenses for the elderly are so astronomical that unless the average couple makes solid financial plans for their future, upon the death of one spouse, the sur-

¹⁶¹ *Id.*; see Mitchell, *What Love is About, as They Lay Dying*, Wash. Post, Sept. 6, 1985, at D2, col. 1.

¹⁶² Streitfeld, *supra* note 160, at B5, col. 1.

¹⁶³ *See id.*

¹⁶⁴ *Id.*

¹⁶⁵ *See id.*

¹⁶⁶ *See id.*

¹⁶⁷ *Id.* A famous 1975 suicide pact was that between Dr. Henry P. Van Dusen, President Emeritus of Union Theological Seminary, and his wife. *See* O. RUSSELL, *FREEDOM TO DIE* 349-50 (1977). Dr. Van Dusen suffered for five years from a severely crippling stroke, and his wife was seriously incapacitated by arthritis. *Id.* They overdosed on sleeping pills. *Id.* at 350.

In early March 1983 the noted author Arthur Koestler, who over the years had become a strong supporter of "auto euthanasia," ended his life by ingesting a lethal dose of drugs. Blake, *Rootless Cosmopolitan of the Age*, TIME, Mar. 14, 1983, at 96. Suffering from old age, Parkinson's Disease, and other related illnesses, the seventy-seven year old Koestler decided that he could no longer endure. *Id.* His apparently healthy fifty-six year old wife also committed suicide with him. *Id.*; see also Blake, *Going Gentle into that Good Night*, TIME, Mar. 21, 1983, at 85.

¹⁶⁸ *See* Streitfeld, *supra* note 160, at B5, col. 1.

viving spouse may find herself largely discarded.

2. Teenagers

Teenage suicides present a disturbing and dramatic problem. However, whether a real or fabricated crisis exists is debatable.¹⁶⁹ The 1960s and early 1970s saw a dramatic increase in the actual number of suicides committed by youths. By 1975, the peak year for teenage suicides, the total number of ten to fourteen year olds committing suicide was 11,594.¹⁷⁰

Viewed internationally, the American problem is not a crisis. Among young males, the U.S. suicide rates of 19.7 per 100,000 teenagers is below the rates found in Switzerland (33.5), West Germany (21.2) and Norway (20.2). For young women, the American rate (4.6) also falls below that found in Denmark (5.0), France (5.0) and Japan (6.4).¹⁷¹

Even though these statistics may not suggest a U.S. teenage suicide rate of crisis dimension, one should be concerned by the fact that 31% of high achieving teenagers listed in *Who's Who Among American High School Students* have actually contemplated suicide, and 4% have attempted it.¹⁷² Furthermore, 71% of those surveyed suggested that suicides for this particular age group could be effectively prevented by teenage/parent suicide awareness programs, counseling in schools, more direct involvement between parents and teacher-counselors, and crisis-prevention hot lines.¹⁷³ The survey also listed the following factors as most contributive to suicide:

Feelings of personal worthlessness, 86 percent; feelings of isolation and

¹⁶⁹ See Carlson, *Is There a Teen Suicide Crisis?: Or Are Social Scientists After More Federal Research Funds?*, Wash. Post, Jan. 25, 1987, at B5, col. 1; Del Bello, *Needed: A U.S. Commission on Teen-Age Suicide*, N.Y. Times, Sept. 12, 1984, at A31, col. 1; see also Gelman & Gangelhoff, *Teen-Age Suicide in the Sun Belt*, NEWSWEEK, Aug. 15, 1983, at 70 (stating that every year approximately 5,000 teenagers kill themselves and as many as half a million more attempt the act, corresponding to a 300% increase in adolescent suicides since 1955).

¹⁷⁰ Carlson, *supra* note 169, at B5, col. 1. See generally Murdoch, *Gay Youths' Deadly Despair: High Rate of Suicide Attempts Tracked*, Wash. Post, Oct. 24, 1988, at 1, col. 5.

¹⁷¹ *Id.*

¹⁷² McCormack, *High-Achieving Teen-Agers Tell of Considering Suicide*, Wash. Post, Sept. 14, 1986, at A7, col. 1. A Stanford University psychiatrist, Dr. Vincent D'Andrea, has found that each year 15 out of every 100,000 students kill themselves, and that 1 in 10 suicide attempts succeed. PARADE, Oct. 23, 1983, at 8.

¹⁷³ McCormack, *supra* note 172, at A7, col. 1; see also Kehr, *Perspective: Teen Suicide*, Wash. Post, Sept. 13, 1983, at B5, col. 1; Morse, *Schooling Kids on Suicide Prevention*, Wash. Post, Oct. 12, 1984, at C5, col. 2.

loneliness, 81 percent; pressure to achieve, 72 percent; fear of failure, 61 percent; drug and alcohol use, 58 percent; communication with parents, 58 percent; actual failure, 56 percent; lack of attention from parents, 50 percent; lack of stability in the family, 49 percent; fear for personal future, 41 percent; unwanted pregnancy, 32 percent; parental divorce, 24 percent; sexual problems, 23 percent; financial concerns, 14 percent.¹⁷⁴

When four Bergenfield, New Jersey, youths successfully committed a pact suicide, wide national news coverage of this event "seems to have had a strong impact on other teenagers,"¹⁷⁵ for there were thirty-five similarly related cases during the succeeding four weeks.¹⁷⁶ Research undertaken at the University of California at San Diego of more than 12,500 teenage suicides between 1973 and 1979 found that "'the national rate of suicide among teen-agers rises significantly just after television news or feature stories about suicide,' with the increase proportional to the amount of network coverage."¹⁷⁷ A similarly focused study restricted to the greater New York City area found that in the weeks following the airing of three television fictional movies on the subject of suicide, both suicide attempts and actual completions increased.¹⁷⁸

¹⁷⁴ McCormack, *supra* note 172, at A7, col. 1; see Peck, *Towards a Theory of Suicide: The Case for Modern Fatalism*, 11 OMEGA 1 (1980-81). In analyzing case histories and suicides of 132 people between the 12 and 34, Peck observed that almost one-third of youths feel suicide victims were found to have experienced fatalistic thought (e.g., one's destiny is determined, and she is powerless to effect change). See *id.*; see also A. PARKER, *SUICIDE AMONG YOUNG ADULTS* (1974); E. SHNEIDMAN, *DEATH AND THE COLLEGE STUDENT* (1972).

¹⁷⁵ Streitfield, *The Aftermath of Suicides: Attention Must Be Paid, but How Much and at What Price?*, Wash. Post, May 25, 1987, at C5, col. 1. Cobb County in Atlanta, Georgia, has become part of a "suicide cluster" afflicting half a dozen United States communities, with 9 having a 33% higher suicide rate than the national average. TIME, Nov. 14, 1988, at 29.

¹⁷⁶ Streitfield, *supra* note 175, at C5, col. 1; see also Dobbs, *Four N.J. Teenagers Commit Suicide*, Wash. Post, Mar. 12, 1987, at A3, col. 3; *Illinois Suicides Similar to New Jersey Teen-Agers*, Wash. Post, Mar. 14, 1987, at A3, col. 1.

¹⁷⁷ Russell, *Teen-Age Suicides Linked to TV Coverage of Subject*, Wash. Post, Sept. 11, 1986, at A3, col. 5.

¹⁷⁸ See *id.*; see also Phillips & Carstensen, *Clustering of Teenage Suicides After Television Stories about Suicide*, 315 NEW ENG. J. MED. 685 (1986).

In a case brought in Ft. Lauderdale, Florida, a mother was found guilty of child abuse after her daughter's suicide and sentenced to one year in prison, two years of community control, and three years of probation. See Colburn, *"Psychological Autopsy" in the Courtroom*, Wash. Post Health Mag., Apr. 19, 1988, at 13, col. 1. This case was not only the first reported case of child abuse charges after a child's suicide, but also the first time a "psychological autopsy" was admitted as evidence in a criminal trial. *Id.* The court found that the suicidee was forced by her mother to be a nude dancer and was so exploited that her condition in life became hopeless. *Id.*

Some commentators suggest that suicide "contagions" and "clusters" can be prevented by presenting suicide news stories in a negative, even gruesome manner instead of in a neutral or sympathetic posture.¹⁷⁹ Since front-page stories may have a more significant impact on its readers,¹⁸⁰ front-page coverage of suicides should be written to suggest that the suicidee should have sought counseling from a counselor or friend.¹⁸¹

If a teenager believes that death would be beneficial, should society recognize the right to end her life with assistance or autonomously? It has been suggested that for teenagers with either catastrophic illnesses or severe mental impairments, this right of self-determination should be preserved.¹⁸² Obviously, if the recognition of such a right were conferred upon unemancipated teenagers, it should be fashioned in the same manner as if the right had been given to an incompetent. Either a family member or a close personal friend would be given the legal responsibility to determine whether actions of enlightened self-determination should be undertaken. Naturally, any action taken by the teenager's legal representative would be taken in concert with the attending physician. For emancipated teenagers, their status would be akin to that of any other competent individuals. Thus, under present law, they would be allowed to refuse treatment. The mechanisms for promoting or implementing this policy of enlightened self-determination will be developed in Parts IV and V of this Article.

Findings contradict about imitative suicide following motion pictures. In a current study drawing from a nationwide sample of suicide cases, the results indicated no evidence of increased numbers of suicides after the broadcast of three movies: "A Reason to Live," "Surviving" and "A Desperate Existence." See Berman, *Fictional Depiction of Suicide in Television Films and Imitation Effects*, 145 AM. J. PSYCHIATRY 982 (1988). However, some support was interestingly found for an imitation effect in "Surviving" (where carbon monoxide poisoning was the leading actor's method of suicide) when, during a four-week period, a significant increase in suicides by youths 24 years and younger was recorded after the movie's showing. See *id.* Finally, to the extent that fictional presentations of suicide may, in fact, serve as stimuli for imitative behavior, the effect apparently depends upon complex interactions among characteristics of the stimulus, the observer of that stimulus, as well as conditions of time and geography. See *id.* at 985.

¹⁷⁹ See Streitfield, *supra* note 175, at C5, col. 1.

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² See Price, *Pro-Suicide Activists Call for Right to Assist*, Wash. Times, Mar. 13, 1987, at 6A, col. 2 (quoting Professor Margaret P. Battin, University of Utah).

C. Indirect Self-Destructive Behaviors

Indirect self-destructive behavior comes in many forms: hyper-obesity, smoking, drug and alcohol addiction (substance abuse), motorcycle and auto racing, and skydiving.¹⁸³ This type of overt behavior distinguishes itself from direct self-destruction by two specific criteria: time and awareness. Thus, since the effect of this indirect behavior is long range and spans a period of years, people exhibiting the behavior pattern are either unaware of the effects of their actions or simply do not care. However, in no case do they consider themselves a suicidee nor does society seek to commit them involuntarily for restraint of these actions.¹⁸⁴

The concept of indirect self-destructive behavior, then, is so broad that it embraces a continuum of escalating danger, which begins with self-punishment for minor risks and ends with more serious injuries ultimately leading to death.¹⁸⁵ Yet, its essential function is to "deny helplessness and replace it with coping mechanisms that in theory enhance self-esteem."¹⁸⁶ Accordingly, cigarette smoking may create a feeling of reinforced security yet still permit "one to spit smoke in the face of the world."¹⁸⁷ It has been suggested that to some degree all individuals seek to deny their utter helplessness against bad luck, fate, and death by indulging in some form of indirect self-destructive behavior. Naturally, society bears the ultimate cost of such indulgent behavior.¹⁸⁸

Generally, indirect self-destruction proceeds so slowly that it is often ignored. An individual may damage herself by overeating, seeking stress, neglecting physical fitness, excessively drinking alcohol, or choosing to forego treatment when an illness is contracted.¹⁸⁹ Moreover, alcoholism and drug addiction have been characterized simply as forms of "slow suicide."¹⁹⁰

¹⁸³ Farberow, *Indirect Self-Destructive Behavior: Classification and Characteristics*, in *THE MANY FACES OF SUICIDE* 15, 19 (N. Farberow ed. 1980). Other destructive behaviors include mountain climbing, scuba diving, hand gliding, trapeze performing in circuses, acting as stuntmen, boat racing, and playing violent contact sports such as boxing. *Id.*

¹⁸⁴ *Id.* at 17.

¹⁸⁵ See Litman, *Psychodynamics of Indirect Self-Destructive Behavior*, in *THE MANY FACES OF SUICIDE*, *supra* note 183, at 28.

¹⁸⁶ *Id.* at 39.

¹⁸⁷ *Id.*

¹⁸⁸ See *id.*

¹⁸⁹ Achte, *The Psychopathology of Indirect Self-Destruction*, in *THE MANY FACES OF SUICIDE*, *supra* note 183, at 41.

¹⁹⁰ *Id.* at 51; see also D. DE CANTANZO, *supra* note 43, at 20.

In the pursuit of pleasure, many young males have participated in high-risk sports which yield high mortality figures. Although reliable statistics are difficult to obtain which document both the frequency of injuries and fatalities for the fifteen to forty year old age group, the Metropolitan Life Insurance Company has compiled some interesting statistics.¹⁹¹ In 1976, out of a total 400,000 recorded motor vehicle racing drivers, 145,000 were drag racers, 115,000 motorcycle racers, and 28,000 stock car racers. From 1967 to 1976, 436 fatalities from motor-vehicle racing were recorded: 104 from stock car racing, 77 from motorcycle racing, and 74 from automobile drag racing. Interestingly, during approximately the same period, out of 700 registered balloon pilots, only 16 fatalities resulted from balloon flying. Thirty thousand people had delta kites or hang gliders by 1975 and 85 fatalities had resulted from these flights. It was further estimated that 7% of all hang glider flights ended either in injury or fatality. In 1973, glider plane pilots numbered 13,395. From 1960 through 1973, 73 deaths occurred in glider plane flying. Sport parachuting has drawn over 40,000 people, with 10 to 12 fatal jumps being made each year. Another report documents the fact that after sky diving three or more years, 71% of the sky divers sustained injury.¹⁹² It has been submitted that habitual actions with cumulative probabilities making it very likely that the individual undertaking them will die as a consequence could properly be considered suicidal.¹⁹³

Society both encourages and promotes these types of "athletic" or destructive behaviors. Why are some exercises of rational self-determination sanctioned and even encouraged for the enhancement of local and state revenues while others are not? It has been suggested that the sport-affiliated behaviors provide a type of "psychological service"¹⁹⁴ to society in that those participating in various media-hyped high risk sports fulfill psychological needs for the viewing spectators.¹⁹⁵ Not only may a spectator participate vicariously with the actual participant but the spectator may actually "defy, or even experience, death."¹⁹⁶ One commentator observes:

¹⁹¹ See Delk, *High-Risk Sports as Indirect Self-Destructive Behavior*, in *THE MANY FACES OF SUICIDE*, *supra* note 183, at 393, 395.

¹⁹² *Id.* at 395.

¹⁹³ See D. DE CANTANZO, *supra* note 43, at 21; see also L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1371-73 *passim* (2d ed. 1988) (analyzing governmental interference with life styles — recreational (motorcycling) and otherwise).

¹⁹⁴ Delk, *supra* note 191, at 406.

¹⁹⁵ See *id.*

¹⁹⁶ *Id.*

Circus acts, whenever possible, it seems, are labeled "death-defying" to maximize their appeal to the public. This suggests that the greater the risk of death to the performer, the more the spectator is attracted to the event. A very daring but successful "defiance" of death may vicariously impart to the observer a feeling of elation and well being, and even a momentary sense of immortality.¹⁹⁷

Even though all these self-destructive behavioral actions have a high adverse economic effect on the public as to the maintenance and extension of health care for those who pursue these high-risk or suicidal actions and sustain injuries, little — if any — public effort has been launched to interfere blatantly or restrict these acts of self-endangerment. Only with the advent of the AIDS epidemic have voices been raised suggesting a public quarantine of all known carriers of the disease in an effort to restrict its spread by promiscuous sexual conduct.¹⁹⁸ Surely if a large segment of modern society can be seen as viewing indirect self-destructive behaviors with ambivalence if not condonation, hope at least exists for direct forms of enlightened self-determination through what, traditionally, has been termed voluntary active euthanasia.

D. Aiding, Assisting, Abetting, or Advising

The first do-it-yourself handbook on suicide, *A Guide to Self-Deliverance*,¹⁹⁹ was published in London by EXIT — The Society for The Right to Die with Dignity, a forty-five-year-old London-based organization.²⁰⁰ Largely because of a subsequent judicial proceeding involving EXIT, this thirty-two page pamphlet is now distributed to members of the organization who are at least twenty-five-years-old and who have a

¹⁹⁷ *Id.*

¹⁹⁸ See Duncan, *Public Policy and the AIDS Epidemic*, 2 J. CONTEMP. HEALTH L. & POL'Y 169 (1986). As might be expected, AIDS represents a significant risk factor for suicide. Marsuk, Tierney, Tardiff, Gross, Morgan, Hsu & Mann, *Increased Risk of Suicide in Persons with AIDS*, 259 J. A.M.A. 133 (1988).

The Editor of the *Journal of the American Medical Association* recently illustrated circumstances in which life is no longer worth living and thus active euthanasia can be tolerated. Lundber, *It's Over, Debbie and the Euthanasia Debate*, 259 J. A.M.A. 2141, 2142 (1988). He would condone administering a large and fatal overdose of either morphine or potassium when a patient suffers "with the acquired immunodeficiency syndrome who has widespread Kaposi's sarcoma, *Pneumocystis carinii* pneumonia, and the dementia of cerebral toxoplasmosis." *Id.*

¹⁹⁹ SOCIETY FOR THE RIGHT TO DIE WITH DIGNITY (EXIT), *A GUIDE TO SELF-DELIVERANCE* 1 (1981) [hereafter EXIT GUIDE].

²⁰⁰ See Leo, *supra* note 22, at 49.

three-month standing membership.²⁰¹ Its basic aim is to assist the reader in overcoming the fear of death, particularly, in overcoming the fear of the agony of dying.²⁰²

The pamphlet lists five different methods of suicide or self-deliverance under the headings: "Sedative Drugs and Plastic Bags"; "Drugs and Car Exhaust"; "Sedative Drugs and Hypothermia"; "Sedative Drugs and Drowning"; and "Sedative Drugs Alone" (wherein appropriate dosages of various drugs and especially sedatives are listed).²⁰³ The pamphlet counsels against acting in haste during periods of depression or loneliness and suggests consultation with Samaritans or family members.²⁰⁴ Before making a final decision concerning self-deliverance, one is cautioned to consider the reasons for undertaking the act "over a substantial period of time." Factors to consider are whether the particular problems associated with the decision can be overcome by seeking medical or other help, or by changing lifestyles and realizing that an unsuccessful suicide attempt could leave one with a damaged brain or in worse physical condition than before the suicide attempt.²⁰⁵ Finally, consideration should be given to the fact that "of those who survive apparently serious suicide attempts . . . , a significant proportion find that they can cope with life after all."²⁰⁶ If things go awry, if there are snags in the suggested procedures, or if the information provided proves incorrect, EXIT encourages the pamphlet reader to report such matters to EXIT headquarters.²⁰⁷

As an organization, EXIT neither advocates nor does it express displeasure with suicide. Rather, it maintains a position of neutrality regarding such decisions as ones of personal belief or judgment.²⁰⁸ By advocating a policy of rational self-deliverance, when freely chosen and appropriate, EXIT believes that the act, itself, should not be taken as euphemistic. Self-deliverance

²⁰¹ The Author, after certifying that he did not seek to read the Guide for personal reasons, but instead only for scholastic research, was allowed to sit in the reading room, under close observation, of the Radzinowicz Library in the Institute of Criminology at Cambridge University and take notes. No xerox reproduction of the pamphlet was allowed. A copy of these notes are on file with the *U.C. Davis Law Review*. Subsequent page references are to the pamphlet, not to the Author's notes.

²⁰² See EXIT GUIDE, *supra* note 199, at 1.

²⁰³ See *id.* at 16-23.

²⁰⁴ *Id.* at 9.

²⁰⁵ *Id.* at 10.

²⁰⁶ *Id.*

²⁰⁷ *Id.* at 15.

²⁰⁸ See *id.* at 4.

implies that the person dies by his or her own hand, with a peaceful mind for reasons that those closest will endorse. They will know that they were not intended to feel guilt or grief, but rather share sympathetically in a final display of courage and good sense. No word to express the concept has existed until now . . . since no one so far has made any effort to distinguish between the fulfillment of self-deliverance and the tragedy of other forms of suicide.²⁰⁹

As a socio-political organization, EXIT's objective is to work for the enactment into legislation of the previously defeated 1969 Voluntary Euthanasia Bill by Parliament.²¹⁰ This Bill would authorize physicians to administer euthanasia to a patient who thirty days previously executed a written declaration requesting euthanasia in the presence of two witnesses.²¹¹ Two physicians — one of them a consultant — must certify in writing that the at-risk patient would be or is presently suffering from a painful and incurable physical disease likely to cause severe distress and render the patient incapable of a tolerable existence.²¹² Ideally, the declaration would be executed well before the patient's good health declines and could be cancelled at any time.²¹³ The Bill's authors designed the thirty-day waiting period to provide a type of built-in safeguard against what might be taken either as an impulsive or a reluctant decision.²¹⁴

The Central Criminal Court convicted and sentenced Nicholas Reed, general secretary of EXIT, for conspiring, aiding and abetting another's suicide with "L".²¹⁵ On appeal, the Criminal Division of the Court of Appeal in London held that Reed neither counseled nor procured suicide with *L* either by or through publication and distribution of *The Guide to Self-Deliverance*.²¹⁶ Rather, Reed was properly convicted because he put *L* "in touch" with a potential suicide victim knowing full well that *L* would assist in the act of suicide if the situation so demanded.²¹⁷ Thus, Reed either aided, abetted, counseled, or procured a suicide as prohibited by statute and was properly convicted of conspiracy.²¹⁸ In reducing Reed's criminal sentence to eighteen months for the offense, the court refused to accept the mitigation argu-

²⁰⁹ *Id.* at 6.

²¹⁰ *See id.* at 4.

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *R. v. Nicholas Reed*, 1982 Crim. App. 819 (providing lower court's decision).

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

ment that the agreement between *L* and Reed was only designed to promote a fuller understanding of suicide through counseling with individuals in stressful "at-risk" situations.²¹⁹ Counseling included both discouraging suicide when feasible and actively participating in its completion depending upon an assessment of the most appropriate course of action.²²⁰ The court reasoned that regardless of the alternative or conditional nature of the agreement, the obvious intention was still to conspire to aid or abet a suicide.²²¹

In *Attorney General v. Able*,²²² the Attorney General sought to halve the distribution of the same pamphlet by applying for a declaration that future supplies of the booklet to those who were known to be — or were likely to be — considering or intending to commit suicide constituted an offense under Section 2(1) of The Suicide Act of 1961,²²³ of aiding, abetting, counseling or procuring the suicide of another.²²⁴ The Attorney General was alarmed because some 8,000 requested copies of the manual had been sold to EXIT members and the pamphlet's popularity was increasing.²²⁵ The Attorney General chose the civil action rather than criminal prosecution because the members of EXIT's executive committee "were respectable persons and had issued the booklet out of genuine and strong held beliefs."²²⁶

After reviewing the pamphlet's contents at length, the court refused the application for the declaration and concluded that while the distribution of the pamphlet could be an offense, before such a conclusion could be reached,

it must at least be proved (a) that the alleged offender had the necessary intent, that is he intended that that person would be assisted by the booklet's contents, or otherwise encouraged to take or to attempt to take his own life; (b) that while he still had that intention he distributed the booklet to such a person who read it; and (c) in addition, if an offense under S 2 of the 1961 Act is to be proved, that such a person was assisted or encouraged by so reading the booklet to take or attempt to take his own life, otherwise the alleged offender cannot be guilty of more than an attempt.²²⁷

Thus, the court held that no offense under the Suicide Act of 1961 had

²¹⁹ *Id.* at 819-20.

²²⁰ *Id.*

²²¹ *Id.*

²²² *Attorney General v. Able*, 1984 All E.R. 277.

²²³ 9 & 10 Eliz. 2, ch. 60 (1961).

²²⁴ *Able*, 1984 All E.R. 277.

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* at 288.

been committed.²²⁸

The Suicide Act of 1961 abolished not only the crime of suicide,²²⁹ but also the crime of attempted suicide.²³⁰ But, interestingly, the Act does not entirely erase either the former religious prohibition of suicide as immoral nor disregard the common law that held anyone who either incited or assisted another to commit suicide was herself guilty of abetting a crime.²³¹ Therefore, the Suicide Act "in effect continues the old law by making it a statutory crime to aid, abet, counsel or procure a suicide or attempted suicide."²³² Notwithstanding the symbol or legacy of immorality that still attaches to the Act's "on-record"²³³ validity, the actual practice of its enforcement is so light that but one or two prosecutions a year are made, yielding only a suspended sentence or probation.²³⁴

The social and religious standards that hold suicide immoral prevent the law from dealing forthrightly with the dilemma. The law's resolution allows one to commit suicide legally, yet prohibits aid by another in completing the act.²³⁵ This "old-fashioned" manner of thinking devalues enlightened acts of self-determination for perceived theological harmony. This presents untold problems for incurably disabled but competent individuals who desperately need assistance in ending their travail with a semblance of dignity and compassion.

Two French authors, Claude Guillon and Yves le Bonniec, both members of the French Association for the Right to Die in Dignity (ADMD), co-authored *Suicide: Operating Instructions*.²³⁶ Acclaimed as a best seller, the book aims to present a number of nonviolent death alternatives "which do not degrade human dignity . . . by giving people the possibility of dying by methods less atrocious than the classic ones of razor blades, revolvers or hanging."²³⁷ A prominent psychiatrist at a major Parisian hospital countered by stating, "Nine out of 10 people need help to be taught how to live, not how to die."²³⁸

²²⁸ *Id.*

²²⁹ 9 & 10 Eliz. 2, ch. 60 (1961).

²³⁰ G. WILLIAMS, *TEXTBOOK OF CRIMINAL LAW* 530 (1978).

²³¹ *Id.*

²³² *Id.*

²³³ *Id.*

²³⁴ *Id.* at 530-31.

²³⁵ *See id.* at 531.

²³⁶ *Id.*; Maubouche, *Final Choices: Popular Suicide Guide Enrages the French*, Wash. Post, Sept. 6, 1982, at C1, col. 6.

²³⁷ G. WILLIAMS, *supra* note 230, at 531.

²³⁸ *Id.*

Derek Humphry helped to organize HEMLOCK, an organization dedicated to supporting the right of terminally ill individuals to take their own lives.²³⁹ In addition, he is the author of two novels on suicide. In *Jean's Way*,²⁴⁰ he relates how he assisted his terminally ill wife in committing suicide.²⁴¹ His second book, *Let Me Die Before I Wake*,²⁴² is an effort to analyze case histories of terminally ill patients who sought successfully to end their lives.²⁴³ In the process of relating the successes, precise drug dose information is listed for any readers wishing to follow through themselves.²⁴⁴ As a pro-choice society, HEMLOCK " 'does not encourage people to die; we encourage them to hang on for as long as possible.' But . . . 'if for medical reasons life becomes unbearable, self-deliverance is a civil right that patients should have.' " ²⁴⁵

In the United States, the First Amendment to the Constitution protects the "right to receive ideas,"²⁴⁶ even though the information received may disclose effective and painless ways of ending one's life.²⁴⁷ However, the state may restrict the area of distribution and the manner of solicitation of such literature.²⁴⁸ Although assisting suicide is still a crime in a number of states,²⁴⁹ the power and force of the First Amendment is such that suicide manuals could not be suppressed.²⁵⁰ The First Amendment right prevails even though there is widespread concern that an unchecked distribution of suicide manuals might put those individuals who are depressed or suicidal "over the brink."²⁵¹ In *Brandenburg v. Ohio*,²⁵² in a concurring opinion, Mr. Justice Douglas summed up the central dilemma of First Amendment mandates and state interference by stating that: "The line between what is permissible and not

²³⁹ See Podgers, *supra* note 34, at 1499.

²⁴⁰ D. HUMPHRY, *JEAN'S WAY* (1987).

²⁴¹ See *id.*

²⁴² D. HUMPHRY, *LET ME DIE BEFORE I WAKE* (1986).

²⁴³ See *id.*

²⁴⁴ See Blake, *supra* note 167, at 85.

²⁴⁵ Podgers, *supra* note 34, at 1499.

²⁴⁶ *Martin v. City of Struthers*, 319 U.S. 141, 143 (1943). See generally J. NOWAK, R. ROTUNDA & J. YOUNG, *CONSTITUTIONAL LAW* ch. 18 (2d ed. 1983) (discussing freedom of speech).

²⁴⁷ See J. ROBERTSON, *THE RIGHTS OF THE CRITICALLY ILL* 30 (1983).

²⁴⁸ See, e.g., *Heffron v. International Soc'y for Krishna Consciousness, Inc.*, 452 U.S. 640 (1981).

²⁴⁹ See *supra* notes 106-118 and accompanying text; see also J. ROBERTSON, *supra* note 247, at 29, 30.

²⁵⁰ See *supra* notes 246-47 and accompanying text.

²⁵¹ See *supra* note 244 and accompanying text.

²⁵² 395 U.S. 444 (1969).

subject to control and what may be made impermissible and subject to regulation is the line between ideas and overt acts."²⁵³ In the Court's *per curiam* opinion, it was stated that the only reason for allowing an interference with free speech and the free press would be when the use of force or violation of the law, "is directed to inciting or producing imminent lawless action and is likely to incite or produce such action."²⁵⁴ The publication, sale, and distribution of a suicide manual of the type distributed by EXIT would not fall within the *Brandenburg* exception because such a manual does not *advocate* "imminent lawless action."²⁵⁵ First, the action is not lawless since suicide has been decriminalized and assisted suicides are seldom prosecuted with vigor. Second, mere publication does not strike a chord of immediacy since a "once over" perusal would not normally produce or give rise in people to precipitous action; rather reflecting upon it, as well as other sources, would occur over time.²⁵⁶

Even though state legislation prohibits assisting others in their acts of suicide,²⁵⁷ and such assistance is theoretically prosecutable under general homicide statutes,²⁵⁸ in fact, the enforcement and prosecution of

²⁵³ *Id.* at 456.

²⁵⁴ *Id.* at 447.

²⁵⁵ *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1206.

²⁵⁶ See G. WILLIAMS, *supra* note 230, ch. 14, § 11. A similar "moral" problem exists with the free distribution, without prosecution, of terrorist manuals that describe how bridges may be demolished and human lives thus brought into chaos.

²⁵⁷ See *supra* notes 106-18 and accompanying text.

In Texas as early as 1902, a state court determined that since suicide was not illegal, aiding a suicide could not be a criminal act. See *Grace v. State*, 44 Tex. Crim. 193, 194, 69 S.W. 529, 530 (1902).

In 1908 the same court held that suicide assistance must be passive — not active — to be a defense to murder. See *Sanders v. State*, 54 Tex. Crim. 101, 112 S.W. 68 (1908). Accordingly, shooting an individual upon request would equate with active homicide for which the acting party would be charged with first degree murder. *Id.* at 105, 112 S.W. at 70.

In a 1901 New Jersey case, a court held that since suicide was not a crime, the public good would not prevent one from taking a life that "may be worthless to the public." *Campbell v. Supreme Conclave Improved Order of Heptasophs*, 66 N.J.L. 274, 49 A. 550, 553 (1901). But see *State v. Ehlers*, 98 N.J.L. 236, 238, 119 A. 15, 17 (1922) (attempted suicide a punishable act).

²⁵⁸ See Comment, *The Right to Die*, 7 Hous. L. Rev. 654, 656 (1970). In *State v. Cobb*, 229 Kan. 522, 625 P.2d 1133 (1981), the Kansas Supreme Court sustained a first degree murder conviction of the defendant who, acting upon the decedent's request, injected him with an overdose of cocaine and then proceeded to shoot him. In Australia, aiding and abetting the death of another by her own hand is a crime punished as homicide. See Sharma, *Euthanasia in Australasia*, 2 J. CONTEMP. HEALTH L. &

these acts is negligible.²⁵⁹ Yet, again, in theory these acts of assistance could be classified as involuntary manslaughter,²⁶⁰ coercion,²⁶¹ general recklessness,²⁶² or criminal negligence.²⁶³ As to the issue of remoteness of actions imposing liability, the Model Penal Code requires the actual result to involve a kind of harm or injury that is *not remote* or accidental,²⁶⁴ or — if reckless or negligently induced — “not within the risk of which the actor is aware, or in the case of negligence, of which he should be aware. . . .”²⁶⁵

[W]hat will usually turn on the determination [of whether the defendant caused the result] will not be the criminality of defendant's conduct but rather the gravity of his offense. Since the actor, by hypothesis, has sought to cause a criminal result or has been reckless or negligent with respect to such a result, he will be guilty of some crime under a well-considered penal code even if he is not held for the actual result, *i.e.* he will be guilty

POL'Y 131, 139 (1986). In 1986 Rosewell Gilbert, 75, was sentenced to life imprisonment for the premeditated murder of his 51-year-old wife. *Gilbert v. State*, 487 So. 2d 1185 (Fla. 1986). He shot her twice in the head, thereby seeking to end her painful and progressively degenerative conditions of osteoporosis and Alzheimer's disease. *Id.*

²⁵⁹ See *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1206; see also Vesey, *She Wanted to Die, So He Killed Her: Man Gets Probation as Dead Woman's Family Praises His Devotion*, Wash. Post, Nov. 24, 1985, at 1, col. 1 (Maryland woman decided to kill herself, gave gun to her friend, and asked him to pull the trigger).

²⁶⁰ See Annotation, *Manslaughter — Person Liable*, 95 A.L.R. 2d 175, 191 *passim* (1964) (person other than actor liable for manslaughter); ARIZ. REV. STAT. ANN. § 13-1103 (1978); COLO. REV. STAT. § 18-3-104 (1978); CONN. GEN. STAT. ANN. § 53a-56 (1981); ORE. REV. STAT. § 163.125 (1983); see also *Regina v. Creamer*, 3 All E.R. 257 (Crim. App. 1965). In *Creamer* the court determined: “A man is guilty of involuntary manslaughter when he intends an unlawful act and one likely to do harm to the person and death results which was neither foreseen nor intended. It is the accident of death resulting which makes him guilty of manslaughter as opposed to some lesser offence, such as assault” *Id.* at 262.

²⁶¹ See, e.g., *Stephenson v. State*, 205 Ind. 141, 179 N.E. 633 (1932). In *Stephenson* the defendant shamed and disgraced a female companion into a (coerced) suicide that amounted to murder. *Id.* After the female companion was subjected to two days of various sexual perversions, she bought six tablets of bichloride of mercury and ingested them in an effort to commit suicide. *Id.* She was initially unsuccessful in this act, but ten days later she died — apparently of a combination of shock, loss of food and rest, a reaction to the poison, and infection and lack of proper treatment. *Id.*

²⁶² See, e.g., J. HALL, *GENERAL PRINCIPLES OF CRIMINAL LAW* 115, 123, 131-33 (2d ed. 1960). Charges of recklessness may arise even though the actor believed that harm would not occur, is indifferent whether or not it occurs, or, traditionally, is grossly ignorant or criminally inattentive to her actions. *Id.* at 115, 123.

²⁶³ See *id.* at 114, 116, 120, 127.

²⁶⁴ MODEL PENAL CODE § 2.03(2)(b) (Official Draft 1962).

²⁶⁵ *Id.* § 2.03(3).

of attempt, assault or some offense involving risk creation Thus the issue in penal law is very different than in torts. Only in form is it, in penal law, a question of the actor's liability. In substance, it is a question of the severity of sentence which the Court is authorized or obliged to impose.²⁶⁶

The concept of assisted rational suicide, or the right of terminally ill patients to take their own life, is being accepted more and more by both the legal and medical professions.²⁶⁷ One prominent Los Angeles attorney has observed that state laws which classify attempted suicide as a crime have been eliminated for the most part and that there is a growing movement to reform the laws against aiding or abetting suicide.²⁶⁸

Because of the plethora of complex moral and ethical questions raised under suicide-assistance laws, prosecutors are generally reluctant to bring strong actions under them.²⁶⁹ A member of the New York County District Attorney's office in Manhattan observed that a case-by-case method is used to evaluate suicide incidents brought under specific state laws prohibiting either aiding or abetting suicide.²⁷⁰ He stated: "Incidents in which persons may have questionable motives such as financial gain, for encouraging or assisting another person's suicide . . . are the type of case we'd be likely to prosecute."²⁷¹ He continued by noting that for cases involving terminally ill patients, prosecutions are less likely to be maintained simply because the courts appear reluctant "to convict defendants when the moral issues of mercy and the patient's privacy rights are involved."²⁷²

A former Chairman of the American Medical Association's Ad Hoc Council on Medical Ethics acknowledged recently that a physician must recognize that after advising a patient regarding the prognosis of her disease, the patient has a right to decide what course of treatment will follow, including the choice of suicide.²⁷³ Perhaps somewhat overstating the matter, he concluded, "The day of paternalism of the profession is long since gone."²⁷⁴

²⁶⁶ *Id.* § 2.03 comments at 133-34 (Tent. Draft No. 4, 1955).

²⁶⁷ See Podgers, *supra* note 34, at 1500-01.

²⁶⁸ See *id.* at 1501.

²⁶⁹ See *id.*

²⁷⁰ See *id.*

²⁷¹ *Id.*

²⁷² *Id.* Over the last 25 years or so, both suicide and attempted suicide have lost the status of crimes. G. GRISEZ & J. BOYLE, JR., *supra* note 14, at 122.

²⁷³ See Podgers, *supra* note 34, at 1501.

²⁷⁴ *Id.*; see also Appelbaum & Roth, *Patients Who Refuse Treatment in Medical Hospitals*, 250 J. A.M.A. 1296 (1983); McKegney & Lange, *The Decision to No Longer Live on Chronic Hemodialysis*, 128 AM. J. PSYCHIATRY 267 (1971).

The compelling state interest to prevent assisted suicide is quite weak when the act is undertaken because of a terminal or severely handicapping illness, but admittedly more tenable when a decision to undertake suicide is made when death is not imminent. The state has persuasive arguments to see that its citizens remain healthy, care for their dependents and honor their contracts to fulfill binding legal obligations.²⁷⁵ Yet, the most humane and practical manner in which to deal with the immediate conundrum is to have suicide and aiding and abetting its execution defined statutorily as noncriminal.²⁷⁶

The purpose of such model legislation would be to allow competent, but incapacitated and terminally ill citizens, to end their lives. Such a uniform legislative declaration would allow those lacking capacity, owing to infancy, mental incompetence or unconsciousness, to utilize the protections of surrogate decision making and exercise the same liberty as their competent fellow citizens.

With regard to the competent decision maker, the states should enact legislation making it lawful for any individual to furnish another equally competent individual "with the means to commit suicide so long as the person committing suicide takes the last definite step to initiate the suicidal act."²⁷⁷ Under such a legislative design, not only a physician — but anyone for that matter — would be allowed to make available to the individual desiring suicide the means to effectuate the act. In the absence of coercion, the competence of the individual committing the suicide should be recognized as a defense against civil liability for those assisting with the act. A mandatory, formal witness declaration prior to an assisted suicide might provide an additional precaution against foul play "masquerading as an assisted suicide."²⁷⁸

Absent a bold and imaginative legislative plan of action among the states, it will remain for the courts to be brought more and more into

²⁷⁵ See Engelhardt & Malloy, *supra* note 34, at 1021. The Georgia Supreme Court interestingly ruled that based on the constitutional right of privacy (and on denial of medical treatment cases) a prisoner could starve himself to death and the state had no right to destroy such a person's will by frustrating his attempt to die to make a point or to make a statement. See *Zant v. Prevatte*, 248 Ga. 832, 834, 286 S.E. 2d 715, 717 (1982).

²⁷⁶ See Englehart & Malloy, *supra* note 34, at 1037. One commentator has argued that although attempted suicide should be recognized as a crime, it should not always be treated as such. See C. RICE, *supra* note 15, at 81. Instead, the courts should assert a power to drop the criminal charge and require the defendant to undergo psychiatric and medical treatment. See *id.*

²⁷⁷ Englehart & Malloy, *supra* note 34, at 1037.

²⁷⁸ *Id.*

the deliberative decision making process here and thereby intrude not only into the confidentiality of the doctor-patient relationship and patient autonomy, but familial privacy and independence as well.²⁷⁹

E. Suicide Prevention and Management

One line of reasoning holds that an act of suicide can never be "chosen" since overwhelming compulsions make a free choice at best nugatory, if not totally void.²⁸⁰ Accordingly, "no human being, no matter how determined he or she may seem to be to put an end to life, does not somewhere cherish the hope of being saved."²⁸¹ Thus, the aim of suicide prevention and management is not directed toward reducing suicide rates, but to helping distressed "at-risk" individuals find an avenue of self-realization and human dignity rather than of failure.²⁸² In essence, through the efforts to implement the goals of a prevention program, suicide prevention transcends itself into "courageous humanness" where men and women come together in a sincere effort to serve others and seek to "implement humane thinking."²⁸³ In a word, suicide prevention is "crisis intervention."²⁸⁴

Counseling and professional psychiatric therapy form the cornerstones of an effective suicide prevention program.²⁸⁵ Detoxification centers, convalescent centers, particularly for alcoholics, and follow-up care facilities are also utilized.²⁸⁶ Without question, the most effective lay program was started in 1953 by a London Anglican priest who simply used the telephone to communicate with despondent, friendless people

²⁷⁹ See generally Williams, *The Right to Die*, 134 NEW L.J. 73 (1984); Williams, *The Right to Commit Suicide*, in MORAL PROBLEMS IN MEDICINE 388 (S. Gorovitz ed. 1976). Professor Williams observes, "It is still not fully recognized that everyone has not merely a legal but a moral right to drink the hemlock, so far as society in general is concerned." *Id.*

²⁸⁰ See Ringel, *Suicide Prevention and the Value of Human Life*, in PHILOSOPHICAL ISSUES, *supra* note 10, at 206.

²⁸¹ *Id.*

²⁸² See *id.* at 207-08.

²⁸³ *Id.* at 209.

²⁸⁴ *Id.* at 210; see also Garrard, *Community Suicide-Prevention Activities: Greensboro, North Carolina*, in DIAGNOSIS AND MANAGEMENT, *supra* note 155, at 399; Resnik, *A Community Antisuiicide Organization: The Friends of Dade County Florida*, in DIAGNOSIS AND MANAGEMENT, *supra* note 155, at 416; Shneidman & Farberow, *The Suicide Prevention Center of Los Angeles*, in DIAGNOSIS AND MANAGEMENT, *supra* note 155, at 367.

²⁸⁵ Ringel, *supra* note 280, at 210.

²⁸⁶ *Id.*

contemplating suicide.²⁸⁷ Since then, the organization, called "The Samaritans," has become more professional as well as more successful than ever before imagined.²⁸⁸

The underlying principle of the success of The Samaritans is that of simply offering friendship by ordinary people to ordinary people, with no strings attached.²⁸⁹ The befriender expects neither material reward nor gratitude for her work. Should the client wish to unburden herself, the befriender listens as a friend, and may introduce her to a new circle of friends.²⁹⁰ The reintegration of anomic people into society is one of the befriender's primary tasks.²⁹¹ The extent of the period of befriending can be short or long termed. For example, helping an acute reactive depressive through one crisis period would give rise to a relatively short period of befriending, while dealing with a schizophrenic might well extend over a period of time. To prevent an emotional attachment or involvement by the initially untrained befriender with a client, The Samaritans offer a closely supervised training program that places absolute control with each branch director of a Samaritan chapter.²⁹² Thus, The Samaritans take a totally advisory, as opposed to directoral, approach to their work.²⁹³

Interestingly, by rendering the service of advice, oftentimes one may cure another's problem during the course of advising.

Loneliness and the absence of human affection are states which exacerbate any other problems; disappointment, reduction to poverty, etc., seem less impossible to bear in the presence of the affection of another. Hence simply to be a friend, or to find someone a friend, may be the largest contribution one can make either to helping a person be rational or see clearly what is rational for him to do; this service may make one who was contemplating suicide feel that there is now a future for him which is possible to face.²⁹⁴

Organized efforts directed toward suicide prevention began at the

²⁸⁷ See Fox, *The Samaritans*, in *DIAGNOSIS AND MANAGEMENT*, *supra* note 155, at 405.

²⁸⁸ *Id.*

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *Id.*

²⁹² *Id.* at 406.

²⁹³ Fox, *The Recent Decline of Suicide in Britain: The Role of the Samaritan Suicide Prevention Movement*, in *CONTEMPORARY DEVELOPMENTS*, *supra* note 22, at 504, 512 *passim*. See generally Stengel, *Lay Organizations and Suicide Prevention*, in *THE SAMARITANS* 107 (C. Varah ed. 1965).

²⁹⁴ Brandt, *supra* note 22, at 399.

turn of the century.²⁹⁵ Perhaps the very first such organization, the Lemberger *Freiwilligen Rettungsgesellschaft* (Lemberg Volunteer Rescue Society) existed in Germany from 1893 to 1906.²⁹⁶ The organization's volunteers offered aid to not only suicide and attempted suicide cases, but provided other types of emergency service as well.²⁹⁷ A counterpart organization was also founded in Budapest, Hungary.²⁹⁸

The aftermath of World War I, which brought widespread hunger and financial chaos throughout Europe, was also the setting for the development of preventive clinics designed to cope with the *Lebensmud-den* in Vienna.²⁹⁹ The outpouring from people who asked to be protected from their "own desperate thoughts" was significant.³⁰⁰ Indeed, one distinguished commentator noted that "[t]oken human contact could prevent the fatal act in ninety percent of the cases" of suicide.³⁰¹

In the United States, suicide prevention centers were not started until after World War II.³⁰² Indeed, in 1958, the first publicly supported suicide prevention center organized to deal "with the important other-than-purely-medical aspects of individual suicide attempts"³⁰³ was funded by the United States Public Health Service and administered by the University of Southern California in the Los Angeles community.³⁰⁴

Today, a vast network of counseling services is offered by various church and volunteer organizations.³⁰⁵ The National Institute of Mental Health has been successful in showing suicide to be both a health and a social problem and, at the same time, instilling a commitment within mental health leaders to better understand and control it.³⁰⁶ Yet, if this commitment is to be totally realized, a sound financial

²⁹⁵ Farberow & Shneidman, *A Survey of Agencies for the Prevention of Suicide*, in *THE CRY FOR HELP* 136, 137 (N. Farberow & E. Shneidman eds. 1961).

²⁹⁶ *Id.*

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ See J. MEERLOO, *supra* note 18, at 137; see also Ringel, *supra* note 280, at 381. See generally P. MANDELKORN, *HOW TO PREVENT SUICIDE* (1967).

³⁰⁰ J. MEERLOO, *supra* note 18, at 137.

³⁰¹ *Id.*

³⁰² Shneidman, Farberow & Litman, *The Suicide Prevention Center*, in *THE CRY FOR HELP*, *supra* note 295, at 6.

³⁰³ *Id.*

³⁰⁴ *Id.*; see Schulman, *supra* note 120, at 860-62.

³⁰⁵ McGee, *The Volunteer Suicidologist: Current Status and Future Prospects*, in *CONTEMPORARY DEVELOPMENTS*, *supra* note 22, at 480, 481.; see also Neimeyer & Dingemans, *Death Orientation in the Suicide Intervention Worker*, 11 *OMEGA* 15 (1980-1981).

³⁰⁶ See McGee, *supra* note 305, at 480.

basis must be established nationally to support the suicide prevention centers. Volunteer and church-supported projects are not enough. Ideally, suicide prevention should be assumed by local communities with financial support budgeted in the same manner as other mental health clinics and other governmental health programs. Indeed, in an effort to provide continuity of operation, in the future, suicide prevention centers will likely maintain themselves and function through comprehensive mental health clinics.³⁰⁷

1. Involuntary Psychiatric Commitments

Although the criminal laws in some states allow suicides and attempted suicides to be punished, in actuality, convictions under them are infrequent.³⁰⁸ Yet for persons believed to be suicidal, civil commitment procedures still enjoy support.³⁰⁹ For those considered mentally ill, dangerous to themselves, or in need of either care or treatment, state mental health laws authorize both long-term commitment by way of hospitalization or institutionalization.³¹⁰ State legislation also allows for emergency detention in order to prevent suicide.³¹¹

Most commitment statutes exercise a form of benevolent coercion designed as such to prevent self-injury by suicide. Frequently, these statutes not only specify that the defendant must be viewed as dangerous to herself if *not* committed, but also that she must be adjudged mentally ill. Occasionally a statutory specification directs the dangerousness be a *consequence* of the mental illness.³¹² All too often today questions concerning mental illness are decided by physicians using standard psychiatric classifications which they apply with uncertainty. Moreover, a physician may even apply her own personal moral judgment of the lifestyles of the defendants or even lay notions of mental health.³¹³ Complex questions of causation are not considered or confusingly applied since the working assumption made is "that dangerous-

³⁰⁷ See *id.* at 481.

³⁰⁸ See Greenberg, *Involuntary Psychiatric Commitments to Prevent Suicide*, 49 N.Y.U. L. REV. 227 (1974); see also Marzen, O'Dowd, Crone & Balch, *supra* note 86, at 1; Podgers, *supra* note 34, at 1501.

³⁰⁹ See Greenberg, *supra* note 308, at 229. See generally Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA L. REV. 400, 412-15 (1973).

³¹⁰ Greenberg, *supra* note 308, at 229.

³¹¹ *Id.*

³¹² See *id.* at 233.

³¹³ See *id.* at 234.

ness and mental illness imply one another.”³¹⁴

The argument that suicide is harmful must ultimately be rejected as specious. Nothing concrete is known of the fate that befalls one who takes her own life. Practically, it is surely within the realm of imagination to posit a case in which suicide could well be recognized as the lesser of two evils — as when one commits the act either to escape excruciating pain or to be relieved of a terminal illness. Furthermore, under certain conditions, society has shown a more willing condonation or acceptance of suicides: to prevent enemies of the state from obtaining national secrets, to end a desolate and tedious life, to preserve personal or family honor, or to publicize a grave personal or political injustice.³¹⁵

Other case studies reveal that an act of suicide may appear to the outside viewer as an act clearly disproportionate to the precipitating cause.³¹⁶ Attempts at suicide rooted in deep guilt feelings over social experiences that seem insignificant to others comprise one such example. It is quite difficult to remember that distress is *subjective*. Thus, although a nonparticipant may view a stress engendering situation as within the parameters of tolerable distress, this in no way may serve to mitigate the real anguish of the individual who, feeling life intolerable, ends it herself by suicide.³¹⁷

Because of a basic misunderstanding, then, of the personal circumstances that give rise to each suicide and a common tendency to project one's health or well-adjusted attitude to a life situation, society concludes that suicide is undesirable. Furthermore, suicide is both unchristian and atheistic since absolute despair is totally inconsistent with faith in God.³¹⁸ Again, “if one is coping well and observes that most others cope well, one may not be able to understand the behavior of those not coping well.”³¹⁹ Thus, in learning of suicides, the conclusion is inevitably made by the average ordinary “reasonable” person that the act is always totally irrational and indeed, undesirable.³²⁰

Preventing suicides means someone else is making a decision that a potential suicide attempter is better off suffering alive than dead.³²¹ The right to die must be viewed as an extension of the right to live with dignity. Otherwise, the right is nothing more than a hollow principle if

³¹⁴ *Id.*

³¹⁵ *See id.* at 232.

³¹⁶ *Id.*

³¹⁷ *See id.*

³¹⁸ *See generally* D. DE CANTANZO, *supra* note 43, ch. 11.

³¹⁹ *Id.* at 142.

³²⁰ *Id.*

³²¹ *See* Greenberg, *supra* note 308, at 233.

others may first determine whether the act is reasonable or appropriate.³²² "While it may seem anomalous to speak of a 'right to die,' the infringement of this right seriously jeopardizes the right to live one's life as one wishes, and not to live it when it is no longer possible to do so as one wishes."³²³

There is much current debate over the scope and need for involuntary civil commitment; specifically, whether the state should deprive those with mental illness of their liberty or whether involuntary civil commitment should be abolished totally in favor of other systems of social action. How laws should define, delegate and control state action exercised under a broad police power or an equally broad power of *parens patriae* is also of concern.³²⁴

This debate has intensified over the past twenty years both in courts and state legislatures,³²⁵ and has resulted in the recognition of a number of procedural rights for individuals who are subjected to proceedings for commitment: prior notice, an opportunity to be heard, the right to counsel, and the right to judicial review of an initial commitment order.³²⁶ Moreover, the debate has led to the development of substantive commitment criteria (a determination of mental illness and that one is dangerous to self and others)³²⁷ and a requirement for the least restrictive alternative disposition, *i.e.*, least drastic method of treatment.³²⁸ These developments have been regarded as raising serious barriers to efforts designed to offer effective treatment opportunities to those in need of them.³²⁹

A growing number of states have legislatively restricted their authority to force treatment upon the mentally ill.³³⁰ This is all in keeping with a national trend toward deinstitutionalization of mental pa-

³²² See *id.*

³²³ *Id.*; see Kjervik, *The Psychotherapist's Duty to Act Reasonably to Prevent Suicide: A Proposal to Allow Rational Suicide*, 2 BEHAVIORAL SCI. & L. 207 (1984).

³²⁴ See LaFond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL'Y REV. 395 (1985); Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54 (1982).

³²⁵ See Hermann, *Barriers to Providing Effective Treatment: A Critique of Revision in Procedural, Substantive, and Dispositional Criteria in Involuntary Civil Commitment*, 39 VAND. L. REV. 84, 85 (1986).

³²⁶ See *id.* at 89.

³²⁷ See *id.* at 92.

³²⁸ See *id.* at 86.

³²⁹ See *id.*

³³⁰ See Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness and Libertarian Theory*, 31 EMORY L.J. 375, 383 (1982).

tients.³³¹ Community health systems now provide out-patient psychiatric care as a viable alternative to confinement. Indeed, as a consequence of significant and varied litigative success concerning deinstitutionalization and involuntary commitment, a constitutional requirement has been structured mandating that treatment be provided in the least restrictive environment.³³²

Yet, a trend is but a trend, and certainly not a uniform response. The present system of involuntary commitment, tied to hospitalization, fails to embrace current state of the art therapeutic alternatives.³³³ Whether *all* forms of involuntary therapy should be abolished is a vexatious question to be sure.³³⁴ However, consistent with basic concepts of autonomy and self-determination, and the *parens patriae* power of the state, reform could be undertaken by empowering duly appointed guardians to authorize treatment for obviously incapacitated or at-risk individuals.³³⁵ In essence, the use of a guardian could promote a system of involuntary treatment in the least restrictive setting, with confinement to a hospital being used only as a last resort.³³⁶

Today, the trend among state legislatures is to place concern for evaluating and containing the level of dangerousness of the afflicted individual over the concern for the individual's treatment needs.³³⁷ Obviously, an exercise of state power directed toward the prevention of harm to others is an inherent police power, just as state enforced treatment is an

³³¹ In 1955, 559,000 patients were in mental hospitals; in 1980, only 138,000 were institutionalized. Goldman, Adams & Taube, *Deinstitutionalization: The Data Demystologized*, 34 HOSP. & COMMUNITY PSYCHIATRY 129, 131 (1983). See generally Schulman, *supra* note 120, at 855.

³³² See THE LEAST RESTRICTIVE ALTERNATIVES: PRINCIPLES & PRACTICES (H. Turnbull ed. 1981).

³³³ Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 VILL. L. REV. 367, 414 (1983-84).

³³⁴ See Szasz, *On the Legitimacy of Psychiatric Power*, 14 RUTGERS L.J. 479 (1983).

³³⁵ See Myers, *supra* note 333, at 412.

³³⁶ See *id.*; see also LaFond, *An Examination of The Purposes of Involuntary Civil Commitment*, 30 BUFFALO L. REV. 499 (1981). One commentator has suggested that an ideal suicide prevention policy would

save through methods entailing minimal unpleasantness, the lives of as many as possible of those who do not wish to die; interfere as little as possible with those who after some change of consideration persist in wanting to die and afford maximum protection against interference with the liberty of those who pose no threat of suicide.

Greenberg, *supra* note 308, at 242-43.

³³⁷ See Hermann, *supra* note 325, at 94; see also S. BRAKEL, J. PARRY & B. WEINER, *THE MENTALLY DISABLED AND THE LAW* 33-37 (2d ed. 1985) [hereafter THE MENTALLY DISABLED].

exercise of the *parens patriae* power.³³⁸ Actually, state laws designed to prevent harm to one's self function as both an exercise of police power and of *parens patriae* power.³³⁹ "The revisions of civil commitment law in the direction of a single standard of dangerousness therefore reflect a determination that *parens patriae* standing alone is an insufficient basis for commitment of the incompetent mentally ill."³⁴⁰ It has been suggested that the overriding need for treatment of mentally unbalanced individuals could be met by recognizing a standard that permitted commitment for one who "is mentally ill and in need of care or treatment in a mental hospital but because of illness lacks sufficient insight or capacity to make a rational decision concerning treatment."³⁴¹ The long-term testing value of this standard has yet to be determined and verified. Nonetheless, the application of the criterion to the commitment process has an unquestioned and equally far-reaching impact on the rights of the patient while hospitalized and especially her ability or her "right" to refuse treatment.³⁴²

2. Model Laws

Under a proposed Model State Commitment Statute of the American Psychiatric Association,³⁴³ the state's *parens patriae* power is given significant weight and forms the basis for the involuntary emergency admission of an individual for both evaluation and treatment. Involuntary admission is required upon determining that the individual is suffering from a severe mental disorder that prevents informed decision making regarding treatment and is thus *likely* to suffer substantial mental deterioration or physical deterioration or *likely* to harm others.³⁴⁴ Under the provisions of the statute, an additional thirty-day period of commitment is authorized if a judge determines that the individual is *likely* to suffer severe mental deterioration if treatment is not continued.³⁴⁵

This model statute stresses the fact that treatment is the central basis or justification for civil commitment and would mandate treatment only

³³⁸ Hermann, *supra* note 325, at 95.

³³⁹ *Id.*

³⁴⁰ *Id.* at 95-96.

³⁴¹ *Id.* at 100. See generally Goleman, *States Move to Ease Law Committing Mentally Ill: Greater Readiness to Hospitalize Marks Shift in Battle over Patients Rights*, N.Y. Times, Dec. 9, 1986, at Y19, col. 1.

³⁴² THE MENTALLY DISABLED, *supra* note 337, at 37.

³⁴³ See Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275 (1983).

³⁴⁴ *Id.* at 321.

³⁴⁵ *Id.* at 330.

for the incapacitated individual unable to make rational treatment decisions.³⁴⁶ In some respects, the model statute criteria "are broader than those in some current state laws (for example in providing for commitment of persons whose mental state is likely to deteriorate), while in other respects the criteria are stricter (for example in permitting commitment only of persons who lack capacity)."³⁴⁷ One commentator suggests "that relatively few persons who would now be committable as dangerous would not be committable under the Model Law, and that many severely disordered people who are now committable as gravely disabled could be committed under the Model Law."³⁴⁸

II. PERSONHOOD AND THE CONCEPT OF PERSON

A. Competency v. Incompetency

To be treated as a person, one must not only enjoy states of consciousness as well as intentional states, but must also have the capacity to link together by memory experiences which occur at different times.³⁴⁹ Stated otherwise, one must have a capacity for love and engaging in interpersonal relationships or "relational potential."³⁵⁰ Whether rationality or social interactive capacities are the controlling criteria to establish personhood remains an open philosophical question. It has been suggested that an individual's moral standing as part of the moral community should be permitted to end only when a clear breakdown in linkage between bodily integrity and mental or social capacity is established.³⁵¹

To assist in determining when life may be terminated from a point of moral justification, various questions may be posited.³⁵² Nine of the most relevant questions are as follows: (1) Is the individual in question characterized as a person?; (2) If so characterized, does she desire her

³⁴⁶ *Id.* at 331.

³⁴⁷ *Id.* at 335.

³⁴⁸ *Id.* See generally Note, *The Role of Law in Suicide Prevention: Beyond Civil Commitment — A Bystander Duty to Report Suicide Threats*, 39 STAN. L. REV. 929 (1987).

³⁴⁹ See Tooley, *Decisions to Terminate Life and the Concept of Person*, in *ETHICAL ISSUES RELATING TO LIFE AND DEATH* 85-87 (J. Ladd ed. 1979).

³⁵⁰ McCormick, *To Save or Let Die: The Dilemma of Modern Medicine*, in *HOW BRAVE A NEW WORLD?* 339-49 (R. McCormick ed. 1981); see also Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?*, 63 NEB. L. REV. 709, 729 *passim* (1984).

³⁵¹ See R. VEATCH, *A THEORY OF MEDICAL ETHICS* 240-44, 245 (1981).

³⁵² Professor Tooley lists thirteen such questions. See Tooley, *supra* note 349, at 62-63.

own death, and if this is the case, is that a rational desire?; (3) If the person is sustained, what quality of life will be enjoyed? (4) What are the economic costs of maintaining this person's life?; (5) Is the person in an unconscious state and technologically impossible of being restored to consciousness?; (6) Would the termination of life be a matter of active intervention or but a matter of exercising restraint in saving the person's life?; (7) Does the case involve direct or indirect "killing"?; (8) Does the action contemplated require "extraordinary" or only "ordinary" means to maintain the person alive?; (9) Is the illness suffered by the individual *in extremis* of a fatal nature?³⁵³

Another complementary framework for helpful analysis has been set out as so-called indicators of "humanhood" which provide a profile of fifteen qualities or attitudes regarded as necessary for one to be regarded as a "person." The indicators are as follows: self-awareness; self-control; time consciousness; a sense of futurity; a sense of memory; a capability to relate to others; an ability to communicate; the ability to assert control and not display utter helplessness; the ability to display curiosity instead of indifference; rationality; the ability to be emotive and intuitive; and, finally, the capacity for neo-cortical functions.³⁵⁴

In the absence of the synthesizing function of the cerebral cortex, the *person* is non-existent. Such individuals are objects not subjects. . . . Personal reality depends on cerebration and to be dead 'humanly' speaking is to be ex-cerebral, no matter how long the body remains alive.³⁵⁵

What both the nine questions previously posited and the indicators of humanhood have in common is the shared focus on the brain and its proper functioning as the key to the advancement or the preclusion of all the complex human responses and attitudes which identify and recognize a human as a functioning person.

B. *Toward a Uniform Determination of Death?*

The traditional legal definition of death has been, "[T]he cessation of life; permanent cessation of all vital functions and signs."³⁵⁶ As to the

³⁵³ *Id.*

³⁵⁴ See Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, HASTINGS CENTER REP., Nov. 1972, at 1.

³⁵⁵ *Id.* at 3.

³⁵⁶ BLACK'S LAW DICTIONARY 360 (5th ed. 1979).

Daniel Callahan has attempted to provide a stipulative definition of "Natural Death":

[T]he individual event of death at that point in a life span when
(a) one's life work has been accomplished;

determination of death, from a biological standpoint, the law has generally treated the matter as a question of medical fact, determined according to those criteria established by the medical profession in each state.³⁵⁷ Consequently, no consensus is found among the states regarding the matter. Limited application of a brain death standard has been authorized by thirty-three states, with twenty-seven states having codified brain death statutes³⁵⁸ and the remaining six validating brain death determination by judicial cognizance.³⁵⁹

(b) one's moral obligations to those for whom one has had responsibility have been discharged;

(c) one's death will not seem to others as offense to sense or sensibility, or tempt others to despair and rage at human existence; and finally

(d) one's process of dying is not marked by unbearable and degrading pain.

Callahan, *On Defining a "Natural Death"*, HASTINGS CENTER REP., June 1977, at 33.

³⁵⁷ See Brennan & Delgado, *Death: Multiple Definitions or a Single Standard?*, 54 S. CAL. L. REV. 1323 (1981); Dornette, *How Does Your State Define Death?*, LEGAL ASPECTS MED. PRAC., May 1980, at 19; see also High, *Is "Natural Death" an Illusion?*, HASTINGS CENTER REP., Aug. 1978, at 37. High suggests that the central concern should not be directed to determining natural death, but rather three more critical issues: the right to refuse treatment; an analysis of whether or not a particular treatment is — as to each individual case — medically indicated; and what standards are needed to assure proper care for the dying in order that they may die with dignity. *Id.* at 42.

³⁵⁸ See ALA. CODE § 22-31-1 to -4 (1984); ALASKA STAT. § 09.65.120 (1983); ARK. STAT. ANN. § 82-537 (Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7180-7181 (West Supp. 1988); CONN. GEN. STAT. ANN. § 19a-278(b) (1983); FLA. STAT. ANN. § 382.009 (Supp. 1987); GA. CODE ANN. § 88-1716 (1981); HAW. REV. STAT. § 327C-1 (1985); IDAHO CODE § 54-1819 (1988); ILL. ANN. STAT. ch. 110 ½, § 302(b) (Smith-Hurd 1985); IOWA CODE § 702.8 (1979); KAN. STAT. ANN. § 77-205 (1984); LA. REV. STAT. ANN. § 9:111 (West Supp. 1985); MD. ANN. CODE § 5-202 (Supp. 1987); MICH. COMP. LAWS § 333.1021 (1980); MISS. CODE ANN. § 41-36-3 (1981); MONT. CODE ANN. § 50-22-101 (1988); NEV. REV. STAT. § 451.007 (1979); N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-323 (1985); OKLA. STAT. ANN. tit. 63, § 3122 (1986); OR. REV. STAT. § 432.300 (1987); TENN. CODE ANN. § 68-3-501 (1987); TEX. REV. CIV. STAT. ANN., art. 4447t (Vernon Supp. 1988); VA. CODE § 54-325.7 (Supp. 1987); W. VA. CODE § 16-10-2 (1985); WYO. STAT. § 35-19-101 (1988).

³⁵⁹ See *State v. Fierro*, 124 Ariz. 182, 184-87, 603 P.2d 74, 77-78 (1979) (adopting Uniform Brain Death Act); *Lovato v. District Court*, 198 Colo. 419, 428, 601 P.2d 1072, 1081 (1979) (same); *Swafford v. State*, 421 N.E.2d 596, 602 (Ind. 1981) (adopting Uniform Determination of Death Act); *Commonwealth v. Golston*, 373 Mass. 249, 253-55, 366 N.E.2d 744, 748-49 (1977) (adopting brain death standard), *cert. denied*, 434 U.S. 1039 (1978); *New York City Health & Hosp. Corp. v. Sulsona*, 81 Misc. 2d 1002, 1007, 367 N.Y.S.2d 686, 691 (Sup. Ct. 1975) (adopting brain death standard for transplantation purposes); *In re Welfare of Bowman*, 94 Wash. 2d 407, 421, 617 P.2d

State legislative approaches to determining death may be grouped into a three scheme classification. The first scheme consists of seven states that have chosen an "alternative" approach, which provides that the occurrence of death will be recognized when a patient suffers either an irreversible cessation of spontaneous cardiorespiratory function or sustains irreversible cessation of spontaneous brain function.³⁶⁰ This approach allows for a perception, inaccurate though it may be, that there is a recognition of two entirely different phenomena of death.³⁶¹

Eight states provide a second scheme that provides for alternative standards for determining death, while carefully elucidating the specific conditions under which each standard must be applied.³⁶² Typically, these statutes provide that death is recognized legally when there is an irreversible cessation of cardiorespiratory function. If respiration and heartbeat are maintained by means of artificial support, death occurs when the lack of brain function becomes irreversible.³⁶³

Finally, the third scheme has been developed and applied in twelve states by legislative enactment, and applies a brain death standard for determining the occurrence of death.³⁶⁴ Within this group, some legislative directions require irreversible cessation of brain functions to determine death, thereby recognizing a strictly exclusive standard of brain death.³⁶⁵ Other statutes require the recognition of death when there is

731, 738 (1980) (adopting Uniform Determination of Death Act).

³⁶⁰ See IDAHO CODE § 54-1819 (1988) (Uniform Determination of Death Act); KAN. STAT. ANN. § 77-205 (1984); MD. ANN. CODE, art. 43, § 54F (1980); MISS. CODE ANN. § 41-36-3 (1981) (Uniform Determination of Death Act); N.M. STAT. ANN. § 12-2-4 (1978); OR. REV. STAT. § 432.300 (1987); VA. CODE § 54-325.7 (Supp. 1986).

³⁶¹ See Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 109 (1972).

³⁶² See ALA. CODE § 22-31-1 (Supp. 1984); ALASKA STAT. § 09.65.120 (1983); FLA. STAT. ANN. § 382.009 (Supp. 1987); HAW. REV. STAT. § 327C-1 (1985); IOWA CODE § 702.8 (1979); LA. REV. STAT. ANN. § 9:111 (West Supp. 1988); MICH. COMP. LAWS § 333.102 (1980); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1988).

³⁶³ See statutes cited *supra* note 362.

³⁶⁴ See ARK. STAT. ANN. § 82-537 (Supp. 1985); CAL. HEALTH & SAFETY CODE § 7180-7181 (West Supp. 1988); CONN. GEN. STAT. § 19a-278(b) (1983); GA. CODE ANN. § 88-1716 (1981); ILL. ANN. STAT. ch. 110 ½ § 302(b) (Smith-Hurd 1985) (applying only to Uniform Anatomical Gift Act); MONT. CODE ANN. § 50-22-101 (1983); NEV. REV. STAT. § 451.007 (1979) (Uniform Brain Death Act); N.C. GEN. STAT. § 90-323 (1985); OKLA. STAT. ANN. tit. 63 § 3122 (1986); TENN. CODE ANN. § 68-3-501 (1987); W. VA. CODE § 16-10-2 (1985), (Uniform Brain Death Act); WYO. STAT. § 35-19-101 (1988).

³⁶⁵ See ARK. STAT. ANN. § 82-537 (Supp. 1985); ILL. ANN. STAT. ch. 110 ½ § 302(b) (Smith-Hurd 1985); MONT. CODE ANN. § 50-22-101 (1987); NEV. REV. STAT.

an irreversible cessation of brain function. Yet these statutes go further in allowing the use of other medically accepted standards to determine death.³⁶⁶

In exclusively relying upon brain death as the determiner of death, state statutes effectively preclude physicians from letting the circumstances of each individual case govern the ordinary medical procedures used for determining death. Statutes of this nature also preclude utilizing necessary flexibility when the state of the medical technology is such that new more effective advances might obsolesce a traditional brain death standard.

In 1968, in seeking some degree of uniformity between doctors and lawyers in defining death, a number of physicians at the Harvard Medical School issued a report which established four criteria for the diagnosis of irreversible coma:³⁶⁷ (1) unreceptivity and unresponsivity to externally applied stimuli and inner need; (2) no spontaneous muscular movements or spontaneous respiration; (3) no elicitable brain reflexes; and (4) a flat electroencephalogram (EEG).³⁶⁸ The report also suggested that in a case when findings of this type were made, a subsequent verification of them should be undertaken at least twenty-four hours later. Furthermore, on fulfilling the criteria, and before any effort was undertaken to disconnect a respirator, the patient should officially be declared dead.³⁶⁹ The Committee's Report was not presented for the purpose of replacing the more traditional standards for determining death; on the contrary, they were urged only as a complement.³⁷⁰

In 1981 Dr. William Street, a member of the original medical com-

§ 451.007 (1979); OKLA. STAT. ANN. tit. 63, § 3122 (1986); TENN. CODE ANN. § 68-3-501 (1987); W. VA. CODE § 16-10-2 (1985); WYO. STAT. § 35-19-101 (1988).

³⁶⁶ See CAL. HEALTH & SAFETY CODE §§ 7180-7181 (West Supp. 1988); CONN. GEN. STAT. ANN. § 19a-278(b) (1983); GA. CODE ANN. § 88-1716 (1981); N.C. GEN. STAT. § 90-323 (1985); see also *State v. Fierro*, 124 Ariz. 182, 184-87, 603 P.2d 74, 77-79 (1979) (common-law definition still sufficient to establish death despite adopting brain death standard); *Lovato v. District Court*, 198 Colo. 418, 428, 601 P.2d 1072, 1081 (1979) (adopting Uniform Brain Death Act does not preclude continuing to recognize common-law standard).

³⁶⁷ See *A Definition of Irreversible Coma: Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 204 J. A.M.A. 337 (1968).

³⁶⁸ *Id.*

³⁶⁹ See *id.*

³⁷⁰ See The Institute of Safety, Ethics, and the Life Sciences, *Refinements in Criteria for the Determination of Death: An Appraisal, A Report of The Task Force on Death and Dying*, 221 J. A.M.A. 50 (1972).

mittee that wrote the Harvard criteria, observed that in actual implementation the criteria have been found to be too strict in some cases, and too lax in others. Of particular concern to him was the fact that the criteria fail to distinguish adequately between irreversible coma and brain death. He did note that no present records disclose any recovery for patients who met the criteria.³⁷¹

The National Conference of Commissioners on Uniform State Laws approved in 1978 The Uniform Brain Death Act,³⁷² which states: "For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards."³⁷³ Before this Act was superseded in 1980 by the Commissioners' adoption of The Uniform Determination of Death Act,³⁷⁴ four states passed legislation adopting the original 1978 provisions.³⁷⁵

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded in 1981 that the states should adopt a model statute entitled, "The Uniform Determination of Death Act," which would establish much needed clarity and certainty.³⁷⁶ Under this statute, "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."³⁷⁷ Since the issuance of this Report and its subsequent approval by the National Conference of Commissioners on Uniform State Laws in August 1980, it has been adopted legislatively in twenty-four states and the District of Columbia.³⁷⁸ Two states have judicially adopted its standards.³⁷⁹

³⁷¹ See *Brain Death Criteria Described as Obsolete*, Wash. Post, Apr. 22, 1981, at A27, col. 2.

³⁷² UNIF. BRAIN DEATH ACT § 1, 12 U.L.A. 17 (Supp. 1988).

³⁷³ *Id.*; see Capron & Kass, *supra* note 361, at 87.

³⁷⁴ UNIF. DETERMINATION OF DEATH ACT, 12 U.L.A. 310 (Supp. 1989).

³⁷⁵ See ALA. CODE § 22-31-1(b) (1984); NEV. REV. STAT. § 451.007 (1979); W. VA. CODE § 16-10-2 (1985); WYO. STAT. § 35-19-101 (1979); see also Comment, *Medical-Legal Agreements on Brain Death: An Assessment of the Uniform Determination of Death Act*, 8 J. CONTEMP. L. 97 (1982).

³⁷⁶ See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DEFINING DEATH: MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH* 9-10, 172-73 (1981).

³⁷⁷ See *id.* at 172-73.

³⁷⁸ See CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1988); COLO. REV.

Interestingly, public acceptance of the concept of brain death has not been uniform; the average, ordinary person still perceives stoppage of the heart as the sole determinant of death.³⁸⁰ With time, however, and more dramatic "real life" news coverage of tragic Karen Quinlan-type cases, the public will hopefully become more aware, and thus possibly more fully educated on this matter.³⁸¹

A very meritorious and, indeed, persuasive suggestion has been offered as a means of resolving the present confusion and controversy over standards for defining death, specifically, the adoption of neocortical death as the operative and controlling medico-legal standard.³⁸² Defining this type of death as "the irreversible loss of consciousness and cognitive functions,"³⁸³ reveals the present legal inconsistency of upholding surrogate decisions to terminate life-support systems when incompetent patients irreversibly lose all consciousness and cognitive functions — yet failing to recognize neocortical death.³⁸⁴ If this type of death were legally validated, the moral and legal dilemmas inherent within this area of consideration would be resolved because once a physician makes a determination that a patient had irreversibly lost all cerebral qualities of human life, the patient would legally be dead. Thus, artificial life supports and nourishment could be terminated. Substituted judgment and best interest tests would no longer be required in order to *guess* what course of treatment or nontreatment should be pursued.³⁸⁵

While preeminently reasonable, this suggestion is somewhat ahead of its time for social acceptance. Although the tragic choice of continuing "life" or a passive act of cessation of it is often wrenching, the full and

STAT. § 12-36-136 (1987); D.C. CODE ANN. § 6-2401 (Supp. 1988); GA. CODE ANN. § 88-1716 (1986); IDAHO CODE § 54-1819 (1988); ME. REV. STAT. ANN. tit. 22, §§ 2811-2813 (1988); MD. HEALTH-GEN. CODE ANN. § 5-202 (1988); MISS. CODE ANN. § 41-36-3 (1981); MO. ANN. STAT. § 194.005 (Vernon Supp. 1988); MONT. CODE ANN. § 50-22-101 (1987); OHIO REV. CODE ANN. § 2108.30 (Anderson 1988); PA. STAT. ANN. § 10201-10203 (1988); R.I. GEN. LAWS § 23-4-16 (1987); VT. STAT. ANN. tit. 18, § 5218 (1987); WIS. STAT. ANN. § 146.71 (West 1987).

³⁷⁹ See *Swafford v. State*, 421 N.E.2d 596, 602 (Ind. 1981); *In re Bowman*, 94 Wash. 2d 407, 421, 617 P. 2d 731, 738 (1980).

³⁸⁰ See Joynt, *A New Look at Death*, 252 J. A.M.A. 680, 681 (1984).

³⁸¹ See generally J. FEINBERG, *OFFENSE TO OTHERS* (1984); Abram, *The Need for Uniform Law on the Determination of Death*, 27 N.Y.L. SCH. L. REV. 1187 (1981).

³⁸² See Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850 (1986).

³⁸³ *Id.* at 851.

³⁸⁴ *Id.* at 888.

³⁸⁵ *Id.*

open process of making the choice has a cathartic effect on all parties, especially a justice system that demands equality of treatment for all within a forum of open family debate. Put quite simply, too many people *feel* that so long as there is breath, there is life, and would surely feel uncomfortable about the utilization of this abrupt, albeit merciful, standard of neo-cortical death. To compound the "public relations" matter, those who are brain dead remain capable of spontaneous cardiac and respiratory functioning. Indeed, adult patients, declared brain dead, may give every appearance of life, especially to those family members unfamiliar with such technologies as mechanical ventilation and total parenteral nutrition. The average family has repeatedly shown that abrupt and final decisions which would result in the application of the neo-cortical standard of death are not acceptable to their feelings. Although such decisions are agonizing, given the average unsophistication of the dying and the fear of death, education must be undertaken to prepare the ordinary American for acceptance of this standard as well as brain death in general.

C. *Living Wills and Natural Death Acts*

A so-called "living will" is an instrument that indicates its maker's preference not to be started or maintained on a course of extraordinary treatment in the event of accidental or debilitating illness.³⁸⁶ The biggest uncertainty surrounding living wills and their subsequent administration is related to whether health care providers are required — under pain of civil or criminal sanction — to execute the terms of the will. An interlinking concern is whether those participants charged with fulfilling the will's terms will be assured of immunity from civil or criminal prosecution.³⁸⁷ Whether refusing life-sustaining therapies would constitute a suicide largely remains another vexatious and unresolved issue.³⁸⁸ Regardless of these great uncertainties, some thirty-eight states and the District of Columbia have passed living will

³⁸⁶ PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 139 (1983) [hereafter PRESIDENT'S COMMISSION]. See generally SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILLS 1981-1984 (1984); Kutner, *Euthanasia: Due Process for Death with Dignity: The Living Will*, 54 IND. L.J. 201 (1979).

³⁸⁷ See PRESIDENT'S COMMISSION, *supra* note 386, at 140.

³⁸⁸ See *id.* The New Jersey Supreme Court, in *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985), held that declining life-sustaining medical treatment should not be viewed as an attempt to commit suicide.

legislation.³⁸⁹

Those jurisdictions recognizing living wills still address the types of medical techniques that are "extraordinary" and the type of circumstances that will "demonstrate that the person's previously expressed desire to forego treatment continued up to the time immediately prior to his or her medical disability."³⁹⁰ Without legislative decisions that tackle these issues with clarity, the courts will be faced with a case-by-case determination of the parameters of life.³⁹¹

To correct some of the weaknesses and uncertainties of living will legislation, more and more states are enacting Natural Death Acts.³⁹²

³⁸⁹ See ALA. CODE §§ 22-8A-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. § 82-3801 to -3804 (1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988); COLO. REV. STAT. §§ 15-18-101 to -113 (1987); 1985 Conn. Acts 85-606 (Reg. Sess.); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. § 6-2421 to -2430 (Supp. 1988); FLA. STAT. § 765.01-15 (West 1986); GA. CODE ANN. §§ 88-4103 to -4106 (Harrison Supp. 1988); IDAHO CODE ANN. §§ 39-4502 to -4509 (Supp. 1988); ILL. ANN. STAT. ch. 110 ½, para. 701 (Smith-Hurd Supp. 1988); IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1988); IOWA CODE ANN. §§ 144A.1 to .11 (West Supp. 1988); KAN. STAT. ANN. § 65-28-101 to -109 (1985); LA. REV. STAT. ANN. § 40:1299.58.1-.10 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1987); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1988); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1988); MONT. CODE ANN. §§ 50-9-101 to -111 (1987); NEV. REV. STAT. §§ 449.540-.690 (1986); N.H. REV. STAT. ANN. §§ 137-H:1-16 (Supp. 1987); N.M. STAT. ANN. §§ 24-7-1 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -322 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1988); OR. REV. STAT. §§ 97.050-.090 (1984); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590h, § 1-11 (Vernon Supp. 1988); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1988); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54-325.8:1-12 (Supp. 1987); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1988); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West Supp. 1988); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986). See Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737.

³⁹⁰ J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 246, at 765.

³⁹¹ *Id.*

³⁹² Twenty-one states and the District of Columbia have either natural death or death with dignity legislation. See ALA. CODE §§ 22-8A-1 to -10 (Michie Supp. 1988); ARK. STAT. ANN. §§ 82-3801 to -3804 (Michie Supp. 1985); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Michie Supp. 1988); FLA. STAT. ANN. § 765.01-15 (West 1988); GA. CODE ANN. §§ 31-32-1 to -12 (Harrison Supp. 1987); IDAHO CODE §§ 39-4501 to -4509 (Michie Supp. 1988); ILL. ANN. STAT. ch. 110 ½, §§ 701-710 (West Supp. 1988); KAN. STAT. ANN. §§ 65-28-101 to -120 (1985); MISS. CODE ANN. §§ 41-41-101 to -121 (Harrison Supp. 1988); NEV. REV. STAT. §§ 449.540-.690 (1985); N.M. STAT. ANN. §§ 24-7-1 to -11 (1981); N.C. GEN.

Spurred by California's passing the Natural Death Act, designed to formally establish the requirements for a "directive to physicians,"³⁹³ other states now allow a validly executed instrument to relieve a physician, staff and hospital from civil and criminal liability for removing or withholding life-sustaining treatment.³⁹⁴ Considerable difference exists among the various legislative programs with respect to assessing penalties for either disobeying the directive of a properly executed instrument or preventing the transfer of a patient to another physician who will respect the patient's wishes.³⁹⁵ The triggering mechanisms of the legislation are often cumbersome and self-defeating. In California, for example, before a patient may seek to avail herself of the provisions of The Natural Death Act, she must first be diagnosed as being in a terminal condition, which means "an incurable condition . . . which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death."³⁹⁶

In actual practice, there is evidence to suggest that a patient's wish to be kept off life-sustaining treatment may be ignored in states where Natural Death legislation exists.³⁹⁷ If attending physicians and health care providers view such legislation as the sole means for both initiating and implementing a decision to forego treatment, and if they believe that the decision cannot be made by a surrogate on behalf of the patient but only in strict accordance with an advance directive that has been properly executed, dying patients may in fact be subject to treatment which is neither requested nor beneficial.³⁹⁸ As an additional fear, an

STAT. §§ 90-320 to -323 (1985); OR. REV. STAT. §§ 97.050-.090 (1984); TEX. REV. CIV. STAT. ANN. art. 4590h (West Supp. 1988); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54-325.8:1-.13 (Michie Supp. 1987); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West Supp. 1988); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (Supp. 1985); WYO. STAT. §§ 35-22-101 to -109 (1988). For a verbatim reproduction of the state Natural Death Acts, see PRESIDENT'S COMMISSION, *supra* note 386, at 318-87.

³⁹³ CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988).

³⁹⁴ See PRESIDENT'S COMMISSION, *supra* note 386, at 141.

³⁹⁵ See *id.*

³⁹⁶ CAL. HEALTH & SAFETY CODE §§ 7187(e)-(f), 7191(b) (West Supp. 1988). In *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), the court observed that even with a set of statutory guidelines such as those in the California Natural Death Act, such guidelines were "so cumbersome that it is unlikely that any but a small number of high educated and motivated patients will be able to effectuate their desires." 163 Cal. App. 3d 186, 194 n.5, 209 Cal. Rptr. 220, 224 n.5 (quoting *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983)).

³⁹⁷ PRESIDENT'S COMMISSION, *supra* note 386, at 144.

³⁹⁸ See *id.*

improper inference may be drawn that a patient does not want life-sustaining treatment *ended* under any and all circumstances unless a directive has properly been executed.³⁹⁹ The truth of the matter might well reveal that a directive was not executed because of either ignorance of its legislative existence, an unawareness of its importance, or even uncertainty regarding how it should be composed.⁴⁰⁰

Generally, the right to die, or natural death acts, apply only to "competent adults,"⁴⁰¹ with children and mental incompetents being excluded. Yet, some jurisdictions have made provision for proxy consent. In North Carolina, the controlling statute allows proxy consent for an irreversibly comatose patient who has not previously executed a living will.⁴⁰² Consent may be given by a spouse, legal guardian, or a majority of the relatives of the first degree.⁴⁰³ No reference is made in the statute to any other type of incompetent patient.⁴⁰⁴ Virginia does not expressly allude to the rights of patients with inadequate decision making capacity and refers only to competent adults.⁴⁰⁵ New Mexico provides for proxy consent for minors, although not for incompetent adults.⁴⁰⁶ Arkansas, however, covers both minors and incompetent adults.⁴⁰⁷

D. Durable Powers of Attorney

As a consequence of the numerous weaknesses encountered with living will legislation and Natural Death Acts, additional safeguards should be utilized for implementing advance directions on life-sustaining modalities of treatment. Specifically, adoption of proxy directives through durable powers of attorney statutes would go far toward assuring an individual's desires regarding treatment.⁴⁰⁸ A sizeable majority of states authorize durable powers of attorney that enable the

³⁹⁹ See *id.*

⁴⁰⁰ See *id.*

⁴⁰¹ See, e.g., CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1988); KAN. STAT. ANN. §§ 65-28, 102 (1985); NEV. REV. STAT. § 449.560 (1985); WASH. REV. CODE ANN. § 70.122.030 (West Supp. 1988).

⁴⁰² See N.C. GEN. STAT. § 90.322 (1985).

⁴⁰³ See *id.*

⁴⁰⁴ See *id.*

⁴⁰⁵ See VA. CODE ANN. § 54-325.8:1 (Michie Supp. 1987). See generally Comment, *Proxy Decisionmaking for the Terminally Ill: The Virginia Approach*, 70 VA. L. REV. 1269 (1984).

⁴⁰⁶ See N.M. STAT. ANN. § 24-7-4 (1986).

⁴⁰⁷ See ARK. STAT. ANN. § 82-3803 (Michie Supp. 1985).

⁴⁰⁸ See PRESIDENT'S COMMISSION, *supra* note 386, at 145, 146.

appointment of a proxy to act after a person becomes incompetent.⁴⁰⁹ The language of these statutes is usually broad enough to accommodate the appointment of a surrogate to facilitate problems which involve health care for the incompetent. However, the statutes were not enacted for remedying these specific problems of incompetence.⁴¹⁰

Since the usual power of attorney ceases when the principal becomes incapacitated, some states have created specific durable powers of attorney whereby an agent's authority continues after a debilitating event happens to the principal.⁴¹¹ In this way, the power may create an "advance proxy directive" allowing an individual to nominate another to make *all* decisions regarding health care in the event the principal becomes incapacitated.⁴¹² This mechanism greatly advances the efficiency and fairness of the whole decision making process for incapacitated persons.

As durable power of attorney statutes are adapted and applied to areas that they were not originally designed to accommodate, care and study must be undertaken to make certain that these original procedures — initially enacted to "avoid the expense of full guardianship or

⁴⁰⁹ See Succession of McCrocklin, 242 La. 404, 137 So. 2d 74 (1962); ALASKA STAT. § 13.26.325 (1985); ARIZ. REV. STAT. ANN. § 14-5501 (1975); ARK. STAT. ANN. §§ 58-501 to -511 (1971); CAL. CIV. CODE §§ 2400-2407 (West Supp. 1988); COLO. REV. STAT. § 15-14-501 (1987); DEL. CODE ANN. tit. 12, §§ 4901-4905 (Michie Supp. 1986); FLA. STAT. ANN. § 709.08 (1988); GA. CODE ANN. § 10-6-36 (1982); HAW. REV. STAT. § 560:5-501 (1985); IDAHO CODE §§ 15-5-501 to -502 (Michie Supp. 1988); IND. CODE ANN. §§ 30-2-11-1 to -3 (West Supp. 1988); IOWA CODE ANN. § 633.705 (West Supp. 1988); KAN. STAT. ANN. §§ 58-610 to -617 (1983); KY. REV. STAT. ANN. § 386.093 (1984); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (1988); MD. EST. & TRUSTS CODE ANN. § 13-601 (1974); MASS. GEN. LAWS ANN. ch. 201B, §§ 1 to 7 (West Supp. 1988); MICH. STAT. ANN. § 27.5495 (Callagan 1980); MONT. CODE ANN. §§ 72-5-501 to -502 (1988); N.J. STAT. ANN. §§ 46:2B-8 (West Supp. 1988); N.M. STAT. ANN. § 45-5-501 (1978); N.Y. GEN. OBLIG. LAW § 5-1601 (McKinney 1988); N.D. CENT. CODE §§ 30.1-30-01 to -05 (1987); OHIO REV. CODE ANN. § 1337.09 (Anderson 1987); OKLA. STAT. ANN. tit. 58, §§ 1051-1062 (West 1988); 20 PA. CONS. STAT. ANN. § 5601 (Purdon 1988); S.D. CODIFIED LAWS ANN. §§ 59-7-2.1-4 (1978); UTAH CODE ANN. § 75-5-501 (1978); VT. STAT. ANN. tit. 14, § 3051 (1987); VA. CODE §§ 11-9.1-2 (1988); WASH. REV. CODE ANN. § 11.94.010 (1987); WIS. STAT. ANN. § 243.07 (West 1987); WYO. STAT. § 34-9-101 to -110 (1977). For verbatim reproductions of the Durable Power of Attorney statutes found in the *Report of the Commission*, see PRESIDENT'S COMMISSION, *supra* note 386, at 393-437. See generally Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779 (1984).

⁴¹⁰ See PRESIDENT'S COMMISSION, *supra* note 386, at 147.

⁴¹¹ See *id.*

⁴¹² See *id.* at 146.

conservatorship proceedings when dealing with small property interests⁴¹³ — are not abused when applied to incapacitated patients.⁴¹⁴ At some point, procedural safeguards may be needed to assure necessary and functional application of the durable powers of attorney. There is no question, however, of their great potential and their already proven success in easing the heavy and emotional burdens of decision making and in allowing the courts to respect individual and familial privacy.⁴¹⁵

E. A Statutory Clarification?

In August 1985 the National Conference of Commissioners on Uniform State Laws approved and recommended for enactment in all states a Uniform Rights of The Terminally Ill Act.⁴¹⁶ This Act authorizes an adult to execute a declaration to her physicians and health care facilities directing the withholding or withdrawing of life-sustaining treatment in the event she is in a terminal condition of health and thereby unable to participate in decisions concerning medical treatment.⁴¹⁷ The scope of the Act is quite narrow in that it provides only *one* way for the wishes of a terminally ill person to be fulfilled.⁴¹⁸ It is designed to avoid inconsistency in approach to decision making, which has continued to plague living will statutes, by providing that the effectiveness of a patient's directive will be executed uniformly in all states.⁴¹⁹

The Act is not intended to affect any existing rights and responsibilities of persons to make medical treatment decisions. Furthermore, its provisions are limited to life-prolonging treatment and to those patients whose terminal condition is incurable and/or irreversible, whose death will soon occur, and who are unable to participate in medical treatment decisions.⁴²⁰ It does not address treating persons who have not executed a statutory declaration nor does it pertain to treatment for minors or treatment decisions made by proxy. Although drawing upon the basic structure and substance of similar existing living will legislation, it simplifies procedures, improves drafting, and clarifies language such as the

⁴¹³ *Id.* at 147.

⁴¹⁴ *Id.*

⁴¹⁵ *See id.*

⁴¹⁶ UNIFORM RIGHTS OF THE TERMINALLY ILL ACT §§ 1-18, 9A U.L.A. 506 (West Supp. 1987).

⁴¹⁷ *See id.*

⁴¹⁸ *See id.*

⁴¹⁹ *See id.*

⁴²⁰ *See id.*

terms "life-sustaining treatment"⁴²¹ and "terminal condition."⁴²² Legislation which endeavors to clarify terms and concepts in this critical area of concern must be applauded as a positive action. Of course, it remains to be seen whether the states view the model as a clarification or an obfuscation.⁴²³

F. Humane and Dignified Death Act

The Hemlock Society of California and Americans Against Human Suffering campaigned to amend the California Constitution to add the Humane and Dignified Death Act. This proposed Act would have recognized and expanded "the inalienable right of privacy [by including] the right of the terminally ill to voluntary, humane, and dignified doctor-assisted aid in dying."⁴²⁴ To exercise the right, a patient would have had to be certified as terminally ill.⁴²⁵ A patient is defined as terminally ill under the proposal if two physicians state that the patient has less than six months to live. The patient would have had to exercise a durable power of attorney in which the patient conveyed authority to order her death to another if a comatose or otherwise mentally disabling condition ensued.⁴²⁶ Although preliminary research indicated strong support for the measure, the initiative received only 130,000 of the needed 450,000 signatures to be placed on the November 1988 ballot.⁴²⁷ However, Americans Against Human Suffering plans another attempt in 1990.

The initiative as drafted would have been an extension of existing state legislation. This legislation allows adults to

execute a directive directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The directive shall be signed

⁴²¹ "Life-sustaining treatment" is defined as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying." *Id.* § 1(4).

⁴²² "Terminal condition" is defined as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." *Id.* § 1(9).

⁴²³ See Marzen, *The Uniform Rights of The Terminally Ill Act: A Critical Analysis*, 1 ISSUES IN L. & MED. 441 (1986).

⁴²⁴ The Hemlock Soc'y of Cal., Humane and Dignified Death Initiative § 1(a) (proposing to amend article 1 of the California Constitution); see also Bond, *Hemlock Society Forms New Organization to Push Assisted Suicide Initiative*, National Right to Life News, Dec. 18, 1986, at 1, col. 1.

⁴²⁵ Parachini, *The California Humane and Dignified Death Initiative*, HASTINGS CENTER REP. (Special Supplement), Jan.-Feb. 1989, at 10, 10.

⁴²⁶ *Id.*

⁴²⁷ *Id.*

by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of execution of the directive.⁴²⁸

For declarants who are patients in a skilled nursing facility to make a valid directive, one of two witnesses must be a patient advocate or ombudsman designated as such by the California State Department of Aging.⁴²⁹ The declarant can revoke the directive regardless of mental state or competency,⁴³⁰ and an exculpatory clause prohibits imposing "criminal or civil liability on the part of any person for failure to act upon a revocation . . . unless that person has actual knowledge of the revocation."⁴³¹

No civil or criminal liability is imposed on a physician or licensed health professional acting under the direction of a physician who fails to effectuate the patient's directive unless she fails to transfer the patient to a physician who will comply with the directive.⁴³² More specifically, actions of withholding or withdrawing life-sustaining procedures from a qualified patient are not regarded as acts of suicide.⁴³³ Section 2443 of the California Civil Code adds that such actions shall not be construed as condoning, authorizing, or approving mercy killing or permitting "any affirmative or deliberate act or omission to end life other than the withholding or withdrawal of health care pursuant to a durable power of attorney for health care so as to permit the natural process of dying."⁴³⁴ Moreover, "an attempted suicide by the principal shall not be construed to indicate a desire of the principal that health care treatment be restricted or inhibited."⁴³⁵ Applying these sections to the proposed Act, the Act would not condone, authorize, or approve mercy killing or permit any affirmative or deliberate act or omission to end life *other than* by a licensed physician and when requested by the patient pursuant to a properly executed legal document.

⁴²⁸ CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1989).

⁴²⁹ *Id.*

⁴³⁰ *Id.* § 7189(a).

⁴³¹ *Id.* § 7189(b).

⁴³² *Id.* § 7191(c).

⁴³³ *Id.* § 7192.

⁴³⁴ CAL. CIV. CODE § 2443 (West Supp. 1989).

⁴³⁵ *Id.*

The Humane and Dignified Death Act is an eloquent effort to build upon the living will legislation, Natural Death Acts such as California's, and durable powers of attorney acts. This proposed Act with existing legislation attempts to recognize that the continuation of life for terminally ill persons under conditions of severe pain and suffering constitutes not only severe cruelty and disregard for human dignity but also an invasion into basic rights of privacy and self-determination. These efforts offer a framework for principled national decision making in this central area of human values and ethical concerns.⁴³⁶

G. *New Beginnings?*

From this analysis, it is obvious that death cannot be identified easily as one event or configuration. The very gradualness of death as a process can be apprehended when one realizes that multiple parts of the body can continue to live even after the disintegration of its central organization.⁴³⁷ Indeed, more and more, one's physiological system does not collapse and fail in a moment's time. Rather, technological substitutes are used, allowing a total integration by a wondrously "evil" computer. Thus, while the vital signs are evidenced, they are both provided and manipulated by machines.

These new medical-legal approaches which define death have one great practical merit; they endeavor to place and to recognize the moment of death earlier in the continuum of life than was allowed by earlier practice and definitional structure. In so doing, the physician's decision to discontinue therapy is made considerably easier, even though "signs of life" are nevertheless present. Death may thus come with dignity and mercy. Not only does this definition of death relieve the family members and health care providers of the deep anguish of dealing with a living corpse, but it also precludes the assessment of heavy economic burdens of caring for one who has lost the basic attributes of personhood. Additionally, under this new definition the body parts that survive death may be harvested and made available to deserving recipients without physicians being fearful and uncertain that their acts might be considered invasions of privacy or criminal assaults.⁴³⁸

The construct for principled decision making is obviously being structured partially in legislative enactments. These enactments bear clear and unmistakable evidence that complex social mechanisms are

⁴³⁶ See generally Engelhardt & Malloy, *supra* note 34, at 1003; Kuhse, *supra* note 28, at 145.

⁴³⁷ See Morison, *Death: Process or Event?*, 173 SCIENCE 694, 695 (1971).

⁴³⁸ See *id.*

currently re-establishing and asserting the right of every individual to enlightened self-determination in deciding her final rite of passage. Passive euthanasia and rational suicide are offensive words of parlance of a time long gone by. Autonomy and enlightened self-determination are the more contemporaneous watchwords of today.

III. EUTHANASIA

Euthanasia, as a term, concept, or attitude has been used under various and confusing circumstances to denote "any good death,"⁴³⁹ "any assistance in helping dying patients in their dying,"⁴⁴⁰ and "only acting directly to kill the dying patient."⁴⁴¹ The intriguing fact emerging from any study of euthanasia, then, will be that it can mean "any good death"⁴⁴² as well as a "morally outrageous death."⁴⁴³

Active euthanasia, then, involves killing while passive euthanasia does not; one is not acceptable while the other is tolerated and accepted more and more. However, how can letting die be more preferable — from a moral standpoint — than helping die? If all other morally relevant factors — intention, motivation, outcome — are the same, why should there be a difference? In truth, the difference between killing and letting die has no moral significance: "In active euthanasia, the doctor initiates a course of events that lead to the patient's death. . . . In letting die, the agent stands back and lets nature take her sometimes cruel course. . . ."⁴⁴⁴

The traditional argument against adoption or acceptance of euthanasia is that a rational patient simply does not and cannot choose euthanasia.⁴⁴⁵ If this argument were so, it must further be maintained that

⁴³⁹ R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* 77 (1976).

⁴⁴⁰ *Id.*

⁴⁴¹ *Id.* Positive euthanasia has been stated as doing something that deliberately ends life and that questions whether the act was suicide (as a voluntary or direct choice of death). The end-goal of both direct or positive and indirect or negative euthanasia is precisely the same — to end a patient's life and to release a patient from pointless misery and dehumanizing loss of bodily functions. See Fletcher, *In Defense of Suicide*, in *SUICIDE AND EUTHANASIA: THE RIGHTS OF PERSONHOOD* 38, 47 (S. Wallace & A. Eser eds. 1981).

⁴⁴² R. VEATCH, *supra* note 439, at 77.

⁴⁴³ *Id.* One commentator has suggested that to clarify the term "biathanasia," the term should refer to a deliberate (or affirmative) act of killing within the concept of mercy death. See Louisell, *Euthanasia and Bianthanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 724 (1973). Louisell also suggests using a synonym, "benemortasia," to clarify or tighten terminology. See *id.*

⁴⁴⁴ Kuhse, *supra* note 28, at 147.

⁴⁴⁵ *Id.*

no autonomous and rational decision could ever be made by a patient to refuse a modality of treatment that was life sustaining.⁴⁴⁶ Yet, this is not what the vast majority of active euthanasia opponents assert. Rather, they maintain that a patient can in fact make a rational choice to follow passive euthanasia, but not active euthanasia.⁴⁴⁷ The inconsistency is obvious. The crucial question that begs answering is: Whether a patient "can rationally choose an earlier death over a later one. . . ." ⁴⁴⁸ Accordingly, if one can make a rational choice to follow passive euthanasia, then she must also be entitled to make a rational choice to follow active euthanasia⁴⁴⁹ or, as termed in this Article, "enlightened self-determination."⁴⁵⁰

A. *Beneficent Euthanasia*

Beneficent euthanasia is defined simply as the painless inducement of a quick death.⁴⁵¹ The most common paradigm of it would include cases when an individual suffers from an irreversible condition such as disseminated carcinoma metastasis, has excruciating and unendurable pain, is beyond reasonable medical doubt that death is imminent, is told of her condition and requests some means of "easy death," and aside from a desire to help such an individual, no other relevant conditions exist.⁴⁵²

At the center of the argument for beneficent euthanasia is a societal obligation "to treat members kindly"⁴⁵³ and consistent with a principle of beneficence.⁴⁵⁴ Suffering should at all times be minimized and kind treatment maximized.⁴⁵⁵ This position must be advocated without fear of it being viewed as another Nazi-type plan for extermination.⁴⁵⁶ The fear that the use of euthanasia, however qualified, runs the risk of destroying the social fabric of society is unfounded.⁴⁵⁷ Beneficent euthanasia's utilization is totally consistent with the basic human need for dignity or self-respect. It should not be viewed as a punishment, but rather

⁴⁴⁶ *Id.*

⁴⁴⁷ *Id.*

⁴⁴⁸ *Id.*

⁴⁴⁹ *Id.*

⁴⁵⁰ R. VEATCH, *supra* note 439, at 135.

⁴⁵¹ M. KOHL, *THE MORALITY OF KILLING* 95 (1974).

⁴⁵² *See id.* at 95-96.

⁴⁵³ *Id.* at 96.

⁴⁵⁴ *Id.* at 100.

⁴⁵⁵ *Id.* at 99.

⁴⁵⁶ *Id.* at 100.

⁴⁵⁷ *See* E. KLUGE, *THE PRACTICE OF DEATH* 149 (1975).

as a matter of meeting this basic need and of executing the societal obligation to treat all members of society kindly or with compassion.⁴⁵⁸

Perhaps at the heart of any discussion of euthanasia is whether such life-ending acts are cruel in and of themselves⁴⁵⁹ and morally justified. Furthermore, any discussion must consider whether in point of fact the act of euthanasia is administered to a *person*.⁴⁶⁰ For one to be recognized as a person, it is commonly regarded as necessary for her to have rational awareness.⁴⁶¹ Query: Is a "betubed, sedated, aerated, glucosed,

⁴⁵⁸ See M. KOHL, *supra* note 451, at 103, 106 (1974).

⁴⁵⁹ See *id.* at 107. The poignancy and humaneness of euthanasia drew national attention when, in its January 8, 1988, issue, the American Medical Association printed an anonymous column entitled, *It's Over, Debbie*, 259 J. A.M.A. 272 (1988). This article was written by a physician who described the manner in which he deliberately injected a 20-year old young woman suffering from ovarian cancer with an overdose of morphine. *Id.* Subsequently, the American Medical Association cited confidentiality and First Amendment issues in refusing to provide the Cook County State Attorney with the name of the physician-author for a grand jury in Chicago. Specter, *AMA Won't Identify Mercy Killer*, Wash. Post, Feb. 17, 1988, at A3, col. 1. The Chief Judge of the Cook County Court later ruled that no crime had been proved and dismissed a later grand jury subpoena demanding the physician-author's identity. Wilkerson, *Judge Stalls Inquiry into a Mercy Killing Case*, N.Y. Times, Mar. 19, 1988, at 6, col. 1; see also Cohn, *Saving Lives, Ending Lives*, Wash. Post Health Mag., Mar. 1, 1988, at 13, col. 1; Cohn, *Story of "Debbie's" Death Isn't Over*, Wash. Post Health Mag., Apr. 12, 1988, at 10, col. 1.

In light of these events, the *American Bar Association Journal* had the Gallup Organization poll 509 lawyers from March 17-24, 1988. See Reidinger, *Lawpoll*, 74 A.B.A. J. 20 (1988). The poll determined by a 49% to 34% margin that these lawyers believe that physicians who did what the resident did for Debbie should face criminal prosecution. *Id.* Interestingly, 46.1% of attorneys over the age of 50 believed that there should not be any criminal prosecution of physicians suspected of currently practicing active euthanasia. *Id.* Only 35.3% believed that there should be prosecutions. *Id.* A majority of the attorneys polled indicated that they would ask their physician for such assistance if they were either in great pain or diagnosed as being hopelessly ill. *Id.*

In a survey conducted by the Hemlock Society in California, 5000 questionnaires were sent to physicians practicing general medicine, cancer treatment, or care of the aged. See Matthews, *Doctors Admit Euthanasia, Group Says*, Wash. Post, Feb. 26, 1988, at A6, col. 1. Of the 588 responses, 79 doctors reported that they had intentionally taken the lives of their terminal patients who had requested them to do so. *Id.* Twenty-nine of these 79 acknowledged performing euthanasia more than three times. *Id.* Among this group of 79, 84% related that they thought their actions were proper, and the remaining 16% said that they did not consider their actions proper. *Id.* Sixty-two percent of the total number of physicians believed that it is "sometimes right" for a doctor to help a terminally ill patient. *Id.* In a Louis Harris poll of 200 physicians for the Harvard Community Health Plan, 66% of those physicians opposed active euthanasia, and 30% supported it. *Id.*

⁴⁶⁰ E. KLUGE, *supra* note 457, at 161.

⁴⁶¹ *Id.*

mechanically manipulated" individual capable of being considered rationally aware?⁴⁶² Arguably, one simply is not a person under these conditions,⁴⁶³ and the individual who acts deliberately and with set purpose to relieve such a suffering, incurably ill, and extremely debilitated individual should not be recognized as having committed an act of murder.⁴⁶⁴ However, for this conclusion to have merit, some type of set criteria or characteristics for personhood must be acknowledged as either correct or acceptable,⁴⁶⁵ or an incontrovertible definition of it agreed upon.⁴⁶⁶ An analysis of the requisites of personhood and their value as a construct for critical decision making has previously been analyzed.⁴⁶⁷ One should note only by way of re-emphasis that these various criteria have yet to achieve the mark of incontrovertibility. Yet, there is very wide agreement that when there is no "relational potential" or a capacity for love and engaging in interpersonal relations — because of an absence of cerebral functioning — there can be no recognition of personhood.⁴⁶⁸

B. *Blurred Definitions and a Posited Clarification*

A good number of physicians and moral theologians use "euthanasia" only in connection with active euthanasia, preferring to refer to "passive euthanasia" as "the right to death with dignity."⁴⁶⁹ The reality of the present situation is that many of the old, chronically ill, debilitated or mentally impaired are *allowed* to die by withholding aggressive medical treatment, and available care goes to young, mentally normal patients.⁴⁷⁰

Since little substance depends upon what label is attached to these present actions, the debate about their distinctions becomes pointless.⁴⁷¹

⁴⁶² *Id.*

⁴⁶³ *See id.*

⁴⁶⁴ *See id.* at 162.

⁴⁶⁵ *See id.*

⁴⁶⁶ *See id.*

⁴⁶⁷ *See supra* notes 349-55 and accompanying text.

⁴⁶⁸ *See* McCormick, *supra* note 350, at 339-49.

⁴⁶⁹ Rachels, *Euthanasia, Killing and Letting Die*, in *ETHICAL ISSUES RELATING TO DEATH* 148 (J. Ladd ed. 1979) [hereafter *ETHICAL ISSUES*]; *see also* J. RACHELS, *THE END OF LIFE* (1986).

⁴⁷⁰ *See* Appelbaum & Klein, *Therefore Choose Death?*, 81 *COMMENTARY* 23, 27 (1986).

⁴⁷¹ *See* Rachels, *supra* note 469, at 148. For example, if someone were to see that an infant were drowning in a bathtub, would it make any difference whether an act of active or passive euthanasia were followed? It could be perceived "just as bad to let it

Indeed, because of the blurring of distinctions between active and passive euthanasia, there is really no distinct difference between the two.⁴⁷²

If death is intentionally caused by doing something or withholding something there is no morally significant distinction to be drawn between an active means to death and a passive means to death. Both are alike or intended means to death; and both the intention and the result are the same — the death of the patient. If one simply withholds treatment, it may take the patient longer to die, and he may suffer more than he would if more direct action were taken and a lethal injection given.⁴⁷³

In an effort to establish analytical clarity, euthanasia should be redefined as either the putting to death or the failure to prevent death in cases of terminal illness or injury.⁴⁷⁴ Several motives could validate the act: to relieve comatoseness, to relieve the effects of permanent suffering and anxiety, or perhaps to relieve a perceived sense of burdensomeness.⁴⁷⁵ Thus, as newly clarified, at least one other person would be considered as causing or helping to cause the death of a competent individual who desires death. In the case of an incompetent, one other person would make a substituted decision in the individual's best interests to either cause death directly or to withdraw some mechanism or process that sustains life.⁴⁷⁶

In its Declaration of Venice of October 1983, the World Medical Assembly concluded that the best interests of the patient should be the operative standard to decide health care matters.⁴⁷⁷ Although this would appear to be a principle grounded in common sense, there are a growing number of situations in which the medical profession operates counter to the best interests of many of its patients. Letting die, to be more specific, often involves a course of *inaction* that directly conflicts with the best interests of a patient. An illustrative case dramatizes this vividly.

A woman is dying of terminal cancer of the throat. She is no longer able to take food and fluids by mouth and is suffering considerable distress. She would be able to live for a few more weeks if medical feeding by way of a nasogastric tube were continued. However, the woman does not want the

drown as to push its head under water," for one action is as iniquitous as the other. Foot, *Euthanasia*, in *ETHICAL ISSUES*, *supra* note 469, at 29.

⁴⁷² See F. HARRON, J. BURNSIDE & T. BEAUCHAMP, *HEALTH AND HUMAN VALUES* 48 (1983).

⁴⁷³ *Id.*; see also Rachels, *Active and Passive Euthanasia*, 292 *NEW ENG. J. MED.* 78 (1975).

⁴⁷⁴ See F. HARRON, J. BURNSIDE & T. BEAUCHAMP, *supra* note 472, at 42.

⁴⁷⁵ *Id.*

⁴⁷⁶ See *id.*

⁴⁷⁷ See *Declaration of Venice on Terminal Illness*, 140 *MED. J. AUS.* 431 (1981).

extra two or three weeks of life because life has become a burden which she no longer wishes to bear. She asks the doctor to help her die. The doctor agrees to discontinue medical feeding, removes the nasogastric tube, and the woman dies a few days later.⁴⁷⁸

Death was obviously in the best interests of this woman. The *method*, however, for allowing its occurrence was not. If a lethal injection had been given, a quick and painless death would have resulted. Rather, after having nasogastric tube removed, she lingered a few days — dying ultimately of dehydration and starvation.⁴⁷⁹ Was it in this patient's "best interests" to be starved to death? Did society in some manner triumph because this individual was forced to suffer an undignified ending instead of being mercifully "killed"?⁴⁸⁰

The sad and very real fact is that a swift and painless death does not always follow from cessation of life-sustaining treatment.⁴⁸¹ The patient whose kidneys have failed and for whom dialysis or transplant surgery is not pursued will generally remain conscious and experience one or all of the following: nausea and vomiting, an inability to concentrate and — eventually — convulsions.⁴⁸² What type of justification can be given for utilizing a method of treatment involving more suffering, instead of less, as being in an individual's best interests?

⁴⁷⁸ Kuhse, *Euthanasia — Again*, 142 MED. J. AUS. 610, 611 (1985).

⁴⁷⁹ *Id.*

⁴⁸⁰ Fearing condonation or actual use of "poisons or similar lethal agents" upon request by a patient would "risk serious abuse," the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research refused to sanction such usage. See PRESIDENT'S COMMISSION, *supra* note 386, at 62 *passim*. However, the Commission did recognize that dying patients' treatment refusals should be honored. *Id.* at 63.

The Law Reform Commission of Canada concluded that euthanasia should not be legalized because such a condonation would severely weaken respect for all human life. Instead, the Commission suggested that a better answer to the sufferings of terminally ill would be to develop more effective palliative care and to search for equally effective pain control therapies. THE LAW REFORM COMMISSION OF CANADA, REPORT 20: EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT 17, 18, 21, 31 (1983). The Commission did recognize that patients are autonomous decision makers and they, acting within this role, have a right to decide whether to discontinue treatment already in progress or even not to commence any type of treatment at all; this expression of one's will is but a simple question of fact. *Id.*

⁴⁸¹ See Kuhse, *supra* note 28, at 147.

⁴⁸² See *id.*

C. Acts of Treatment v. Omissions of Treatment

In classical Greece, medicine had three roles: to alleviate the sufferings of the sick; to lessen the violence of diseases that afflicted them; or to refuse "to treat those who [were] overmastered by their diseases, realizing that in such cases medicine is powerless."⁴⁸³ Indeed, the most common duty of all Greco-Roman physicians was "to help, or at least to do no harm."⁴⁸⁴ Whether a hopeless case was taken by a physician was purely a matter of discretion.⁴⁸⁵ This prevailing sentiment of physicians in this period of civilization found strong precedent in Egyptian and Assyro-Babylonian medicine.⁴⁸⁶ As a medical sentiment, in fact, it continued in vitality throughout the Middle Ages.⁴⁸⁷ In writing in his *De Augmentis Scientiarum* in the late sixteenth and early seventeenth centuries, Francis Bacon is commonly thought to have advanced the conclusion that medicine should seek to prolong life and expand longevity, and the notion has grown in an exaggerated and misdirected manner since that time.⁴⁸⁸

Thus, while a physician's so-called duty to prolong life *qua* life has no classical roots, the idea of "respect for life" does have a rich tradition of observance.⁴⁸⁹ However, even though physicians did not actively seek to terminate a life either by abortion or euthanasia, they neither sought to actively prolong life, itself.⁴⁹⁰ With the rise of Christianity, abortion, suicide, and euthanasia became sins, even though the prolongation of life never became a virtue or a duty.⁴⁹¹

1. Morality of Actions

Pope John Paul II approved the "Declaration of Euthanasia" adopted by the Sacred Congregation for the Doctrine of Faith on May 5, 1980, and in so doing advanced broad principles of humanistic care

⁴⁸³ Amundsen, *supra* note 60, at 23.

⁴⁸⁴ *Id.* at 27.

⁴⁸⁵ *Id.*

⁴⁸⁶ *Id.* at 25.

⁴⁸⁷ *Id.*

⁴⁸⁸ *Id.* at 27-28. Actually, Bacon, while acknowledging the responsibility of the physician to restore health and to mitigate pain, promotes this responsibility only when it "conduces to recovery." *Id.* at 28 (quoting THE PHILOSOPHICAL WORKS OF FRANCIS BACON 487 (J. Robertson ed. 1970)). When there is no hope of recovery, the responsibility is to "make a fair and easy passage from life." *Id.* (quoting THE PHILOSOPHICAL WORKS OF FRANCIS BACON, *supra*, at 487)).

⁴⁸⁹ See Amundsen, *supra* note 60, at 27.

⁴⁹⁰ See *id.*

⁴⁹¹ *Id.*

and treatment for the dying.⁴⁹² Acknowledging that one may seek to utilize advanced medical techniques of an experimental and high-risk nature to combat illness, the Declaration allows for the interruption of these processes when they render unsatisfactory results.⁴⁹³ But before actions of this nature are allowed, the patient's "reasonable wishes" and those of her family must be considered, together with the advice of the attending physicians.⁴⁹⁴ Deferring to physicians' expertise in matters of this nature, the Declaration allows that they "may in particular judge that the investment in instruments and personnel is *disproportionate to the results foreseen*."⁴⁹⁵ Further, they may conclude that "the techniques applied impose on the patient strain or suffering *out of proportion* with the benefits which he or she may gain from such techniques."⁴⁹⁶ Obviously, the Declaration proposes a clear and unequivocal cost versus benefit analysis as a proper standard of evaluation.

One may, of course, consistent with the Declaration, "make do with the normal means that medicine can offer."⁴⁹⁷ Thus, if such a course is followed, "one cannot impose on anyone the obligation to have recourse

⁴⁹² See PRESIDENT'S COMMISSION, *supra* note 386, at 300-07; see also *Sometimes Extending Life Only Prolongs Death*, N.Y. Times, Sept. 23, 1984, at 6E, col. 1.

⁴⁹³ See PRESIDENT'S COMMISSION, *supra* note 386, at 305.

⁴⁹⁴ *Id.*

⁴⁹⁵ *Id.* (emphasis added).

⁴⁹⁶ *Id.* (emphasis added).

Louis E. Gelineau, the Roman Catholic Bishop of Providence, Rhode Island, startled some in the church hierarchy by approving the opinion of a diocesan theologian. Steinfeils, *Bishop Sees No Moral Issue if Feeding Ends in Coma Case*, N.Y. Times, Jan. 12, 1988, at A12, col. 5. The theologian held that, as to the specific case of Marcia Gray, a 48-year old Catholic from South Kingstown who fell into a coma in 1986 after a cerebral hemorrhage, it was permissible to withhold nourishment because of the irreversible nature of the coma. *Id.*; see Hansen, *Right to Die: A Consensus is Emerging with Assistance of Catholic Theologians*, NAT'L CATH. REP., Dec. 11, 1987, at 1, col. 1.

Joseph Cardinal Bernardin of Chicago called for common sense to be employed in resolving this issue and noted:

We are not *morally* obliged to do everything that is *technically* possible. In other words, there are cases when we would not be obliged to provide artificial nutrition and hydration. We are saying that those whose lives have, in fact, entered the dying process should be helped to live the remainder of their lives with full human dignity and with as little pain as possible.

Society for the Right to Die, Newsletter, Summer 1988, at 8; see also *supra* note 6 and accompanying text.

⁴⁹⁷ PRESIDENT'S COMMISSION, *supra* note 386, at 306.

to a technique which is already in use but which *carries a risk or is burdensome*.”⁴⁹⁸ A refusal of this type must not be regarded as an act equivalent to suicide; the refusal represents an acceptance of a human condition as well as a desire to avoid treatment “disproportionate to the results”⁴⁹⁹ or perhaps a wish to prevent excessive financial drains on the patient’s family and community.⁵⁰⁰ Again, the element of economic feasibility of treatment is set forth as a proper vector of force in ultimate decision making. The need to ration scarce medical resources so that they may be expended on those who have a real possibility of recovery is also impliedly recognized in the Declaration.⁵⁰¹ The Declaration concludes that:

[W]hen inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.⁵⁰²

2. Ordinary v. Extraordinary Treatment

The principles of ordinary versus extraordinary life-sustaining processes or treatments are very relative, not only as to time and locale, but also in their application to specific cases. In essence, these concepts serve as basic value judgments that aid in determining whether a given modality of treatment presents an undue hardship to the at-risk patient or whether it provides hope for a direct benefit. Thus, if a particular medical or surgical course of treatment imposes too great a hardship on the patient, and no reasonable *hope of benefit* could be expected, such actions would properly be viewed as extraordinary and not obligatory.⁵⁰³ In practice, many physicians choose to equate “ordinary” with

⁴⁹⁸ *Id.* (emphasis added).

⁴⁹⁹ *Id.*

⁵⁰⁰ *Id.*

⁵⁰¹ See generally *id.* at 300-07. For discussion of allocation of scarce health resources, see Smith, *Triage: Endgame Realities*, 1 J. CONTEMP. H.L. & POL’Y 143 (1985).

One prominent Jesuit theologian, Fr. Edwin J. Healey, has implied that the maximum amount of money that could be expended on an ordinary course of treatment *before* it became extraordinary, was \$2,000.00. See Kelly, *The Duty of Using Artificial Means of Preserving Life*, 11 THEOLOGICAL STUD. 203, 206 n.9 (1950) (citing Fr. Healey).

⁵⁰² PRESIDENT’S COMMISSION, *supra* note 386, at 307.

⁵⁰³ See R. MCCORMICK, NOTES ON MORAL THEOLOGY, 1965 THROUGH 1980, at 565 (1981).

"usual," and "extraordinary" with "unusual" or "heroic" medical practice.⁵⁰⁴ However, once a physician decides to withhold "heroics," no decision making framework exists which would demonstrate which alternative treatments should be either pursued or withheld. For example, sometimes a physician will initiate intravenous feeding, but at a rate that will result in dehydration over time.⁵⁰⁵ While this half-treatment maintains the vital symbol of feeding, it does not sustain the life of the patient over an extended period of time.⁵⁰⁶ Nonetheless, the gesture serves as a type of artificial compromise for physicians wishing to respect the symbol yet act in accordance with patients' needs or expressed wishes.⁵⁰⁷

Determining whether medical or surgical treatment is either ordinary or extraordinary may be regarded as a qualitative statement. In reaching this statement, knowingly or unknowingly, the decision makers involved utilize a substituted judgment to conclude whether — under similar circumstances to those in which the patient *in extremis* exists — they would or would not wish to survive in such a physical and mental state. Obviously, decisions of this moment are made within a varied and yet complex vortex of highly charged emotions.⁵⁰⁸

If the binding force of life is love, people should seek to maximize responses to live in whatever assorted conditions or states they find themselves and, at the same time, minimize suffering and maximize the social good or utility of life.⁵⁰⁹ Simply stated, if an act would cause more harm than good to an at-risk individual and to those associated closely with her, the act could be considered an unloving one. The central point is that in cases of this nature, a basic cost/benefit analysis is almost always undertaken — either on a conscious or unconscious level.⁵¹⁰

On a case-by-case basis, with the standard of reasonableness as the linchpin — as opposed to an unyielding *a priori* ethic — health care providers should balance the gravity of the harm caused by extraordinary care against the utility of the good that will result from such extraordinary actions. The decision makers should be ever mindful of the

⁵⁰⁴ J. CHILDRESS, *supra* note 22, at 166.

⁵⁰⁵ See Hilfiker, *Allowing the Debilitated to Die: Facing Our Ethical Choices*, 308 N. ENG. J. MED. 716 (1983).

⁵⁰⁶ See Childress, *When Is It Morally Justifiable to Discontinue Medical Nutrition and Hydration?*, in *BY NO EXTRAORDINARY MEANS* 67, 81 (J. Lynn ed. 1986).

⁵⁰⁷ *See id.*

⁵⁰⁸ *See* Smith, *supra* note 350, at 734.

⁵⁰⁹ *See id.*

⁵¹⁰ *See id.*

ethical imperative to minimize human suffering at all levels when making ultimate decisions.⁵¹¹ In reality, this mandated balancing test validates a cost/benefit analysis.⁵¹² Only after recognizing that all life is sanctified by creation and is qualitative both to the individual at peril as well as to humankind in general may one inquire whether the medically handicapped individual possesses a sustained ability to enjoy and fulfill loving, interpersonal relationships with others. Ultimately the inquiry must determine whether the present or contemplated course of medical or surgical treatment maximizes the potential utility of life, assuming it exists, or contrariwise, minimizes present suffering.⁵¹³

Measures of an extraordinary nature undertaken for the specific purpose of prolonging a life of suffering are not only unjust to the individual in distress, but also mock societal standards of decency and humanity.⁵¹⁴ The physician's primary responsibility is to relieve suffering when it occurs, not to engineer the survival of a patient at all costs. Indeed, an overly aggressive modality of treatment for a terminally ill patient should be recognized as defiling the very doctrine of *primum non nocere*.⁵¹⁵ If therapy would be futile and to no end other than mere survival, it should not be administered.⁵¹⁶ Thus, the artificial feeding of a terminally ill patient in irreversible coma should be regarded as a *treatment* decision and not mandated except when benefits clearly outweigh burdens.⁵¹⁷

⁵¹¹ See *id.* at 738.

⁵¹² See *id.*

⁵¹³ See Will, *When Homicide is Noble*, in *THE MORNING AFTER*, *supra* note 134, at 84-86. In cases of this nature, the ultimate morality of an action or inaction can never be evaluated properly without referring to the quality of life being extended by the heroic measures. See *id.*

⁵¹⁴ See G. SMITH, *supra* note 31, at 9.

⁵¹⁵ *Primum non nocere* means "[f]irst, do no harm," Frankel, *Curing Lawyers' Incompetence: Primum Non Nocere*, 10 CREIGHTON L. REV. 613, 613 (1977), or "[a]bove all, do no harm." Capron, *Whither Health Care* (Book Review), 133 U. PA. L. REV. 535, 537 (1985) (reviewing P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982) ("[T]he physician was likely to be of greatest assistance by intervening as little as possible and by merely supporting the patient, while nature resolved the illness.")).

⁵¹⁶ Beall, *Mercy for the Terminally Ill Cancer Patient*, 249 J. A.M.A. 2883 (1983).

⁵¹⁷ See AMERICAN MEDICAL ASSOCIATION (AMA), 1982 A.M.A. JUDICIAL COUNCIL CURRENT OPINIONS 9-10; PRESIDENT'S COMMISSION, *supra* note 386, at 288. In a challenge to the Connecticut Removal of Life Support System Act, the Connecticut Supreme Court determined that the Act allowed the removal of artificial life support, such as a gastrostomy tube. *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 209 Conn. 692 (1989). In this particular case, the informed consent of the terminally ill patient's husband and children to the removal had been evidenced, and the patient

Further subtleties and ambiguities in the taxonomy of ordinary versus extraordinary care are seen dramatically in three landmark case opinions. In the case of *In re Dinnerstein*,⁵¹⁸ the court observed that its task was to discern the rather slight "distinction between those situations in which the withholding of extraordinary measures may be viewed as allowing the disease to take its natural course and those in which the same actions may be deemed to have been the cause of death."⁵¹⁹ The court in *Superintendent of Belchertown State School v. Saikewicz*⁵²⁰ stated that no extraordinary means of prolonging life should be pursued when there is no hope that the patient will recover: "Recovery should not be defined simply as the ability to remain alive; it should mean life without intolerable suffering."⁵²¹ Finally, in *In re Quinlan*,⁵²² the court opined: "One would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an *irreversibly doomed patient*."⁵²³

3. Circularity in Terminology

Obviously, the terms ordinary and extraordinary medical treatment are "incurably circular until filled with concrete or descriptive meaning."⁵²⁴ Furthermore, one commentator would abandon these terms in favor of a classification that merely recognizes helpful "treatment medically indicated" for non-dying patients and "curative treatment not indicated" for dying patients.⁵²⁵ Ultimately, these classifications must fail because no objective criteria or concreteness is set forth which would enable a decision maker to act unerringly. No guiding or unyielding a priori standard is proffered — only a standard of situational reasonableness tied to the facts of each case. Perhaps, however, this failure may reveal the very strength of the suggestion: a straight recognition

herself had made her intentions clear. *Id.* The court rejected the state attorney general's argument that the patient's action was tantamount to suicide. *Id.*

⁵¹⁸ 380 N.E. 2d 134 (Mass. App. Div. 1978).

⁵¹⁹ *Id.* at 137 n.7.

⁵²⁰ 373 Mass. 728, 370 N.E. 2d 417 (1977).

⁵²¹ *Id.* at 735, 370 N.E. 2d at 424 (quoting Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J. A.M.A. 387 (1968)).

⁵²² 70 N.J. 10, 335 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

⁵²³ *Id.* at 48, 335 A.2d at 668 (emphasis added).

⁵²⁴ Ramsey, *Euthanasia and Dying Well Enough*, 44 LINACRE Q. 43 (1977).

⁵²⁵ *Id.*; see also Ramsey, *Prolonged Dying: Not Medically Indicated*, HASTINGS CENTER REP., Feb. 1976, at 14, 16.

that no definitive position can be taken.

Another commentator suggests banning the artificial distinctions between ordinary and extraordinary treatment.⁵²⁶ Instead, in a given case, medical treatment is either "morally imperative" or merely "elective."⁵²⁷ For a competent patient, refusing treatment would be accepted when she presented reasons relevant to her declining physical or mental health, or to familial, social, economic or religious concerns, that were valid to her and her alone.⁵²⁸ The incompetent patient is faced with the knowing reality that she is unable to make reasonable choices. Thus, the decision maker in this setting — spouse, parent, child, next of kin, guardian or physician — may refuse treatment on morally acceptable grounds when such an action would seem "within the realm of reason to reasonable people."⁵²⁹

The question remains: What is the test of reasonableness?

A reasonable person would find a refusal unreasonable (and thus treatment morally required) if the treatment is useful in treating a patient's condition (though not necessarily life-saving) and at the same time does not give rise to any significant patient-centered objections based on physical or mental burden; familial, social or economic concern; or religious belief.⁵³⁰

Both of these new ordinary/extraordinary classifications of treatment are inescapably tied to a standard of qualitative living perceived by the at-risk patient, her family, or health care decision maker. Does this mean that all ultimate decisions regarding treatment or nontreatment are essentially cost-benefit ones? The feasibility of structuring a framework for principled decision making will be explored in Part V of this Article.

Ideally the concepts of ordinary and extraordinary means of treatment should totally be disregarded not only because of their imprecise terms of definition and application but also because they tend to support paternalism.⁵³¹ While the standards of customary medical practice determine what ought to be done, both the disease together with the medical technologies needed to treat it displace the patient as the focus of concern. Indeed, the patient-person becomes totally subordinated to the patient-disease-bearer.⁵³² What is demanded, then, is a simple rec-

⁵²⁶ See R. VEATCH, *supra* note 439, at 110.

⁵²⁷ *Id.*

⁵²⁸ See *id.*

⁵²⁹ *Id.*

⁵³⁰ *Id.* at 112. See generally McCormick, *supra* note 350, at 390, 383-99.

⁵³¹ See J. CHILDRESS, *supra* note 22, at 166.

⁵³² *Id.*

ognition that no form of treatment is either obligatory or optional. Rather, everything depends on the patient's condition.⁵³³ Thus,

The only adequate grounds or standards can be found in the ratio of benefits and burdens of the treatment to the patient. But the competent patient should make his or her own assessment, while a proxy must make it for an incompetent patient, using that patient's previously expressed wishes or values when they can be determined.⁵³⁴

D. Legal Distinctions

The legal distinction between acts and omission is made as follows:

In the determination of the existence of a duty, there runs through much of the law a distinction between action and inaction. . . . [T]here arose very early a difference, still deeply rooted in the law of negligence, between "misfeasance" and "nonfeasance" — that is to say, between active misconduct working positive injury to others and passive inaction or a failure to take steps to protect them from harm. The reason for the distinction may be said to lie in the fact that by "misfeasance" the defendant has created a new risk of harm to the plaintiff, while by 'nonfeasance' he has at least made his situation no worse, and has merely failed to benefit him by interfering in his affairs. . . .

. . . .

. . . Liability for "misfeasance" . . . may extend to any person to whom harm may reasonably be anticipated as a result of the defendant's conduct, or perhaps even beyond; while for "nonfeasance" it is necessary to find some definite relation between the parties, of such a character that social policy justifies the imposition of a duty to act.⁵³⁵

Accordingly, the distinction between assisting with a patient's death and allowing her to die parallels the American legal system itself in the way culpability is assigned for either "causing" or "permitting" harm to be inflicted upon others.⁵³⁶ In those instances when an act causes a wrong or harm, liability is assessed against the agent who brought about the harm.⁵³⁷ However, with cases of omission, liability will not be imposed unless a "relationship" between the parties is established.⁵³⁸

The act of turning off a patient's artificial respirator may be classified traditionally as either an act of commission or an act of omission.⁵³⁹

⁵³³ *Id.*

⁵³⁴ *Id.*

⁵³⁵ PROSSER AND KEETON ON THE LAW OF TORTS § 56, at 373-74 (W. Keeton ed. 1984).

⁵³⁶ See Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999, 1004-05 (1967).

⁵³⁷ *Id.* at 1009, 1012.

⁵³⁸ *Id.*

⁵³⁹ See TO LIVE AND TO DIE: WHEN, WHY AND HOW (R. Williams ed. 1973);

Though a distinction may not easily be drawn — because action stems from either activity — the physician, if found to have committed an affirmative act of commission, may be held liable for murdering the patient.⁵⁴⁰ Whether the act of turning off an artificial respirator may be characterized as an act of commission or omission will depend on whether the act caused life to end or whether the act simply failed to sustain life, thereby permitting it to end. The operative verbs here are “caused” and “permitting.”⁵⁴¹ In “acting” or “causing,” an act of intercession is made to terminate life.⁵⁴² With acts of “omitting” or “permitting,” the simple failure to intercede in preserving life recognizes that death is permitted to occur.⁵⁴³ In determining legally whether the act of turning off a hypothetical respirator is one of commission or omission, consideration must also be given to the doctor-patient relationship, patient reliance and expectation as well as to the actual circumstances surrounding the physical act of turning off the respirator itself.⁵⁴⁴

One could argue that the most crucial of all elements — motive — is the testing rod which determines whether acts were those of commission or omission.⁵⁴⁵ Accordingly, a deliberate act of killing, done without a particularized motive or evil will, which is designed to end the suffering of a terminally ill patient, should not be classified as murder.⁵⁴⁶ Since no personal gain or good inures to the actor — but rather to the recipient of the immediate action — this would be another reason not to recognize the act as murder.⁵⁴⁷ Noble intentions, however, are not always exculpatory. For example, if one subscribed to the belief of metempsychosis and decided to hasten another along toward the road to ultimate perfection before she became either tempted or corrupted with

Fletcher, *Legal Aspects of the Decision Not to Prolong Life*, 203 J. A.M.A. 65 (1968).

⁵⁴⁰ Comment, *The Right to Die*, 7 Hous. L. Rev. 654, 659 (1970).

⁵⁴¹ See Fletcher, *supra* note 539.

⁵⁴² See *id.*

⁵⁴³ See *id.*

⁵⁴⁴ See Fletcher, *supra* note 536, at 1015-16. The bounds of moral judgment are certainly questioned when ultimately deciding whether switching off a respirator is an act of active euthanasia or merely passive euthanasia. See Rachels, *supra* note 473, at 78.

In a 1983 California case, *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983), the court distinguished killing and letting die and stated that actions by two doctors in turning off a vegetative patient's respirator, with permission from the patient's wife, was not an act of killing. See *id.* at 1013, 1016-17, 1022.

⁵⁴⁵ See E. KLUGE, *supra* note 457, at 171.

⁵⁴⁶ *Id.*

⁵⁴⁷ See *id.*

moral guilt, this act would surely be held to be murder.⁵⁴⁸

Under one line of philosophical reasoning, acquiescing to a request to kill a fully conscious individual, who for physical or psychological reasons finds life unbearable and finds no other act suitable to bring a resolution to the quandary, would be an act of homicide, not an act of murder. For a murder to be committed, there must be an infringement of rights. Here is nothing more than a simple and volitional release of the right to life.⁵⁴⁹

[I]f something is a right at all, then it can be given up; just as a gift, if it is a gift, can be renounced. Therefore, in cases where the quality of life has reached a certain subjective minimum, the individual has a right to give up that life, to request euthanasia. Consequently, in such cases euthanasia would be morally acceptable.⁵⁵⁰

1. Criminal Liability

To impose criminal liability for not executing a duty owed, the leading American case⁵⁵¹ holds that this duty must be "a legal duty, and not a mere moral obligation. It must be a duty imposed by law or by contract, and the omission to perform the duty must be the immediate and direct cause of death."⁵⁵² Since the relationship between physicians and patient is basically contractual — arising from the nature of an offer and acceptance — a physician has no obligation to treat all comers. Only when the physician undertakes to treat the patient does the law impose a duty to continue treatment, in the absence of a contrary understanding, so long as the individual case requires.⁵⁵³ For the terminal patient desiring a swift, painless death, discharging the attending physician would not only terminate the physician's duty but also would eliminate the primary basis for his criminal liability.⁵⁵⁴ Therefore, the issue of imposing criminal liability arises only when the physician has not been discharged or has failed to withdraw from a case with proper notice, thereby continuing the physician-patient relationship.⁵⁵⁵ The physician may not terminate this relationship by abandoning the pa-

⁵⁴⁸ *See id.*

⁵⁴⁹ *See id.* at 179.

⁵⁵⁰ *Id.*

⁵⁵¹ *People v. Beardsley*, 150 Mich. 206, 113 N.W. 1128 (1907).

⁵⁵² *Id.* at 209, 113 N.W. at 1129.

⁵⁵³ *See Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1207.

⁵⁵⁴ *Id.* at 1208.

⁵⁵⁵ *Id.*

tient; it is within this context that the possibility of criminal liability frequently arises.⁵⁵⁶

The history of American case law of euthanasia presents an interesting record of a system that prosecutes the offense in a limited manner.⁵⁵⁷ In fact, as early as 1916, the predominate view was that even when life was taken with consent to relieve either suffering or "other greater calamity,"⁵⁵⁸ the act might still form the basis of a criminal prosecution, although unlikely.⁵⁵⁹ Consequently, both judges and juries were reluctant to act affirmatively in these situations.⁵⁶⁰

A survey of American case law reveals twelve cases involving active euthanasia: only one case resulted in an actual conviction for murder; three cases maintained convictions for offenses less than murder; seven cases received acquittals; one case failed because of no indictment.⁵⁶¹ In construing this same survey, one authority noted that there were actually nine acquittals in all — seven of which were allowed because of temporary insanity.⁵⁶² However, given that the standards for finding insanity are "tightening,"⁵⁶³ future acquittals of cases similar to these twelve may be more difficult to obtain.⁵⁶⁴

From the list of twelve cases, only one case resulted in a conviction for murder; the plaintiff was convicted of first degree murder and sentenced to death for the electrocution of his six-month-old mongoloid

⁵⁵⁶ *Id.* A new and novel tort action for *wrongful living* has recently been proposed. See Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625, 641 (1980). Under this proposed action, the tort would be recognized as personal and thus redressed only by the individual whose right to die was compromised; or, if that individual should subsequently die, by her surviving representative. *Id.* If the interfering treatment is made and the patient lives, interfering with the right to die involves compensating the living. *Id.* On the other hand, if the interfering treatment causes death earlier than nontreatment, a clear, causal connection exists between the interference and the loss — permanent death. *Id.* Accordingly, the decedent's beneficiaries would appropriately be entitled to wrongful death damages, but damages would be calculated for that period of time by which the treatment shortened life. *Id.*; see also Furrow, *Damage Remedies and Institutional Reform: The Right to Refuse Treatment*, 10 LAW, MED. & HEALTH CARE 152 (1982).

⁵⁵⁷ See *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1213.

⁵⁵⁸ See *id.*

⁵⁵⁹ See *id.*

⁵⁶⁰ *Id.*

⁵⁶¹ See *id.* at 1213 & n.82.

⁵⁶² R. VEATCH, *supra* note 439, at 79.

⁵⁶³ *Id.*

⁵⁶⁴ *Id.* See generally MacKinnon, *Euthanasia and Homicide*, 26 CRIM. L.Q. 483 (1983-1984).

son.⁵⁶⁵ His sentence was subsequently commuted to life in prison, which was in turn reduced to six years.⁵⁶⁶ In two cases involving physicians, both doctors were prosecuted for their efforts to ease the burden of interminable suffering for their patients by injecting them with potassium chloride⁵⁶⁷ and air.⁵⁶⁸ Neither of the physicians defended on the grounds that they were insane when they pursued this action.⁵⁶⁹

2. The International Perspective

An international incident that occurred in 1975 in Zurich, Switzerland, highlights the typical legal problem encountered with a policy of withdrawing tubal feeding.⁵⁷⁰ In January of that year, a prominent Swedish physician, Peter Haemmerli, was accused of murder by starvation for failing to force feed unnamed terminally ill patients in a local hospital over a four-to-five-year period.⁵⁷¹ Although no formal prosecution resulted since there was no allegation of a particular murder, the charge was made as a consequence of a casual conversation between Dr. Haemmerli and a local politically aspiring city council member; the conversation concerned the manner in which terminal patients were treated at the hospital where the doctor was on staff.⁵⁷²

⁵⁶⁵ *Commonwealth v. Noxon*, 319 Mass. 495, 66 N.E.2d 814 (1946).

⁵⁶⁶ *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 508 & 1214 n.86.

⁵⁶⁷ See R. VEATCH, *supra* note 439, at 78. In June 1973, Dr. Vincent A. Montemorano was indicted for taking the life of his patient, a fifty-nine year old Long Island man dying of pharynx cancer, by injecting him with potassium chloride. *Id.* At trial he was found innocent of the action. *Id.*

⁵⁶⁸ See *id.* at 79-80. In New Hampshire in 1950, Dr. Herman Sander was charged with committing the murder of Mrs. Abbie Brown, who was dying of cancer, by giving her intravenous injections of air. *Id.* At trial he was acquitted. *Id.*

⁵⁶⁹ *Id.* at 80. For a brief listing and analysis of the nine or so widely publicized (but not officially reported) mercy-killing court cases against physicians, see O. RUSSELL, *supra* note 167, at 254-56, 260, 329-30.

In a particularly famous 1957 English case, Dr. John Bodkin-Adams was charged with murder for allegedly administering narcotics to relieve pain. *Id.* at 255, 329. The court found Dr. Adams not guilty of murder even though the course of treatment that was administered incidentally shortened the decedent's life. *Id.*

In 1983 two physicians were found innocent of committing murder. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). They had disconnected a patient's respirator and stopped artificial feeding and hydration for the patient. *Id.* These actions were done with written approval of the patient's spouse. *Id.*

⁵⁷⁰ See Culliton, *The Haemmerli Affair: Is Passive Euthanasia Murder?*, 90 SCIENCE 1271 (1975); see also O. RUSSELL, *supra* note 167, at 351.

⁵⁷¹ Culliton, *supra* note 570, at 1271.

⁵⁷² See *id.* at 1271-72.

More specifically, it was revealed that when a comatose stroke victim failed to gain consciousness, and in the opinion of the medical staff would never become conscious, the staff would discontinue tubal feeding and administer a saline solution which would prevent dehydration and maintain the normal chemical balance in the blood.⁵⁷³ Normally, the patient would die within several weeks as a result of starvation and without pain, assuming, of course, that a comatose person is immune from any associated type of pain during this course of treatment.⁵⁷⁴

Although Dr. Haemmerli's treatment is an accepted medical practice, the question must be raised as to the value and the humaneness of letting people die without a semblance of dignity. Does society *profit* from this type of action? What moral or ethical principles are validated — beneficence, respect for persons? Sadly, the only position that is maintained is that of the *status quo* — a position that stresses the continuation of a practice or policy merely because it has been maintained over the years. Contemporary times demand contemporary, thoughtful, and humane responses to the critical issue of terminally ill patients, not lock-step repetitions of past follies.

In Holland, both the attitude towards voluntary active euthanasia and its practice are far different from anywhere else in the world.⁵⁷⁵ In fact, the government has announced that it will structure legal guidelines under which euthanasia will be permitted.⁵⁷⁶ It is unclear whether the guidelines will take the form of actual legislation or administrative regulations.⁵⁷⁷ Regardless of the final governmental approach, the Dutch will retain their present prohibition against active euthanasia and will simply fashion various permissible exceptions to existing law.⁵⁷⁸

⁵⁷³ See *id.*

⁵⁷⁴ See *id.* at 1272.

⁵⁷⁵ See Cody, *Dutch Weigh Legalizing Euthanasia: Gap Cited Between Law and Practice*, Wash. Post, Mar. 16, 1987, at A1, col. 3.

⁵⁷⁶ *Id.*

⁵⁷⁷ *Id.* at A12, col. 5; see Schepens, *Euthanasia: Our Own Future*, 3 ISSUES IN L. & MED. 371, 377 (1988) (listing the guidelines).

⁵⁷⁸ See *id.* An eight-member working committee of the British Medical Association (BMA) is currently studying euthanasia. Although presently "[t]he BMA condemns active involuntary or active voluntary euthanasia, . . . [i]n cases of passive euthanasia there are mixed feelings." Appleyard, *The Last Appointment*, The Times (London), Sunday ed., June 17, 1987, at 22, col. 3.

Switzerland, Uruguay, Peru, Japan, and Germany allow a physician the right to comply under certain circumstances with a patient's request for death medication. See M. HEIFETZ, *supra* note 35, at 96. It is not a punishable crime for a physician to assist with a suicide if her motivation is altruistic. *Id.*

Dr. Pieter Admiraal, a physician at the Reinier de Graaf General Hospital in Delft, is perhaps the most famous open practitioner of voluntary active euthanasia.⁵⁷⁹ Once he determines that a patient is dying, and after receiving a second opinion to this fact, Dr. Admiraal assembles a team of other doctors, nurses, and a priest or representative of the appropriate faith.⁵⁸⁰ "Once a patient has repeatedly and lucidly requested euthanasia and the team have discussed the various alternatives of relief of pain or depression, the decision may be taken to go ahead."⁵⁸¹ Although case law does not require that parties other than the physician and her patient be involved, as a safeguard, the spouse or family is involved or at least advised of the decision.⁵⁸² Once the final decision is made, Dr. Admiraal follows one of two methods to implement it: a barbiturate drip will be used which normally induces a state of unconsciousness within a few hours and death within six or eight hours. In a few cases, a direct injection of barbiturates and curare may be used which results in immediate unconsciousness for the patient and death a few moments later.⁵⁸³

Out of Holland's approximate population of fourteen million people, it is estimated that between six to ten thousand people a year (eight percent of the total number of deaths in the nation) will die as a consequence of active voluntary euthanasia implemented by their physicians.⁵⁸⁴ Currently, only sixty actual deaths are formally declared as caused by euthanasia.⁵⁸⁵ While each death must be investigated by the local public prosecutor, in the event the physician is prosecuted and found guilty, he would *not* be sentenced upon his conviction, thereby avoiding establishing a criminal record.⁵⁸⁶

⁵⁷⁹ Appleyard, *supra* note 578, at 13, col. 1.

⁵⁸⁰ *See id.* at 16, col. 4. As early as 1958, an eminent Cambridge University professor advocated that the least cumbersome approach to the euthanasia problem was to employ referees or committees to determine the validity of requests for voluntary active euthanasia. *See* G. WILLIAMS, *supra* note 38, at 334. He similarly advocated relieving an assisting physician of all liability if she acted in good faith. *Id.* at 340.

⁵⁸¹ Appleyard, *supra* note 578, at 13, col. 4.

⁵⁸² *See id.* at 16, col. 1.

⁵⁸³ *See id.*

⁵⁸⁴ *See id.* at 13, col. 4.

⁵⁸⁵ *See id.* at 18, col. 4.

⁵⁸⁶ *See id.*

In 1984 Maria Barendregt, a 94-year old, became helpless from aging. *Id.* at 20, col. 1. Her mind was intact although she had extended bouts of unconsciousness, and she was unable to care for herself. *Id.* Her physician acquiesced to her demand for euthanasia. *Id.* At trial the court held that proximity to death is not a necessary condition to allow euthanasia. *Id.*

E. A Constructive Proposal: Redefinition and Re-Education

In order to bring a contemporary sophistication to this area of concern and investigation, a strong definitional stance surrounding the terms "euthanasia" and "suicide" must be implemented; quite simply, a re-education. More precisely, the essential taxonomy of euthanasia as a word, concept, principle, attitude, or legal action must be redefined. What have before been recognized as acts of euthanasia would afterwards be known as acts of enlightened self-determination. Actions undertaken within the context of an irreversible medical crisis or terminal illness⁵⁸⁷ would be understood not as an act of autonomous rational suicide (or active euthanasia of oneself), or as a refusal of treatment, but rather as merely an act of enlightened self-determination. For the incapacitated or incompetent individual, the action taken on his behalf by a surrogate decision maker would similarly be viewed; the actions of these decision makers would be judged on their reasonableness and fairness to the terminal patient and her family.

This proposal would foster a new attitude toward death; one that would redefine the basic tasks of medicine by not only recognizing old age as an honorable estate but also by recognizing the unjust and inhumane obligation being imposed upon terminally ill old people who are forced to live through a period of miserable decline and painful helplessness.⁵⁸⁸ The competent decision maker suffering from a severe debilitating (terminal) disease, as well as the similarly situated incompetent would be accorded the privilege of holding first class citizenship; the coordinate result of this new attitude towards health care would be an unyielding recognition that all people possess the total right of personal autonomy.

Rational assisted suicide and all the varieties of euthanasia would no longer be considered. The major focus of all inquiry into actions previously classified as suicide or euthanasia would be simply: Did the indi-

In the celebrated *De Terp* case, a physician and nurse working in an old person's home euthanized three of their patients. *Id.* at 20, col. 3. At trial they were found guilty of murder and sentenced to a year of imprisonment. *Id.* Only on appeal were they freed. *Id.*

⁵⁸⁷ This term would be defined as "an illness in which, on the basis of the best available diagnostic criteria and in the light of available therapies, a reasonable estimation can be made prospectively and with a high probability that a person will die within a relatively short time." Bayer, Callahan, Fletcher, Hodgson, Jennings, Monsees, Sieverts & Veatch, *The Care of the Terminally Ill: Morality and Economics*, 309 NEW ENG. J. MED. 1490, 1491 (1983).

⁵⁸⁸ See Barrington, *Apologia for Suicide*, in PHILOSOPHICAL ISSUES, *supra* note 10, at 90, 99-100.

vidual in question, exercising her powers of rational thinking, exercise an act of enlightened self-determination or autonomy? For the incompetent suffering from a similar terminal illness, the question to be answered would be: Did the surrogate decision maker, acting with rationality and humaneness, and thereby within the best interests of the terminal patient, or employing the principle of substituted judgment for that individual, exercise an act of enlightened self-determination? Obviously, health care providers and courts would presume that an individual under these circumstances or her duly appointed surrogate decision maker acted properly. Obviously, this position is a large quantum leap in not only thinking and hoped-for action, but also it is an eminently fair and reasonable contemporary approach to an age-old problem. New wine in *new* wine bottles is the order of the day and of tomorrow as well.

IV. ORDERS NOT TO RESUSCITATE AND THE WITHDRAWAL OR WITHHOLDING OF TREATMENT

A. *Incremental Steps Toward Passive Euthanasia*

In 1973 the National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care sought to establish a procedure which would allow physicians to indicate further medical treatment was not advantageous to particular patients in their care. Accordingly, the Conference suggested that a rather simple "order not to resuscitate" (ONTR) could be indicated in the progress notes or chart for the distressed patient and, in turn, communicated to the hospital staff.⁵⁸⁹ ONTR can be distinguished from other forms of medical care which terminate pre-existing patient support systems such as the discontinuance of respirators. Specifically, ONTR forbids the use of inotropic or vasopressor drugs that increase cardiac contractility and maintain blood pressure and discourages initiating cardiopulmonary resuscitation (CPR).⁵⁹⁰ A similar order is the do not resuscitate (DNR) order. These orders are often referred to as "no codes" since they normally stipulate that no emergency treatment should be given when cardiac or respiratory failure occurs.⁵⁹¹

⁵⁸⁹ See *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 227 J. A.M.A. 837 (1974) [hereafter *Standards for CPR and ECC*]. See generally Evans & Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 J. A.M.A. 2236 (1985) (describing study of do-not-resuscitate orders at three teaching hospitals).

⁵⁹⁰ See *Standards for CPR and ECC*, *supra* note 589, at 837.

⁵⁹¹ *Id.*; see also Rabkin, Gillerman & Rice, *Orders Not to Resuscitate*, 295 NEW

The inherent problems associated with the 1973 *Cardiopulmonary Resuscitation and Emergency Care Conference Report on ONTR* are as complex today as they were then. The *Conference Report* offers no guidance in determining with reasonable accuracy whether an illness is terminal and whether continued medical treatment contravenes the best interest of a terminally ill patient. Moreover, the *Report* fails to state whether principles of *triage*,⁵⁹² or the efficient and maximum allocation of scarce medical resources — together with quality of life factors — should be evaluated in the deliberative process.⁵⁹³

As a result of "the growing medicalization of death,"⁵⁹⁴ human acts of intervention have nearly totally replaced natural processes.⁵⁹⁵ Indeed, with the almost daily discoveries of "miracle drugs," the perfection of new surgical routines, and the development of new sophisticated mechanical mechanisms designed to assist or to relieve normal bodily processes, illness can no longer be considered as having a natural course of progressive development.⁵⁹⁶ Thus, while pneumonia had once been regarded as the dear friend of elderly ill patients, leading to cardiopulmonary seizure and almost certain death, now frenzied Code Blue Trauma Teams daily race to jump-start hearts with electric paddles and drugs and reinflate lungs with artificial pumps.⁵⁹⁷ Death is no longer a family residential occurrence; rather it has been moved to a hospital or some other type of health-care institution.⁵⁹⁸

The patient's autonomy or right of self-determination in health care issues must always be balanced against the same professional autonomy of a physician. Thus, no force or coercion should compel a physician to treat a patient who has rejected resuscitation when the physician believes that patient resuscitation is an ethical, moral, or professional obligation.⁵⁹⁹ An important recognition of this professional autonomy for

ENG. J. MED. 364 (1976). See generally Miller, *Death with Dignity and the Right to Die: Sometimes Doctors Have a Duty to Hasten Death*, 13 J. MED. ETHICS 81 (1987) (advocating that technical advances in lifesaving technology should be paralleled by advances in semantic and rhetorical approaches to death).

⁵⁹² See Smith, *supra* note 501, at 143.

⁵⁹³ See P. RAMSEY, *THE PATIENT AS PERSON* 239-46 (1970); see also Smith, *Death Be Not Proud: Medical, Ethical and Legal Dilemmas in Resource Allocation*, 3 J. CONTEMP. HEALTH L. & POL'Y 47 (1987); Smith, *supra* note 501, at 143.

⁵⁹⁴ Capron, *Legal and Ethical Problems in Decisions for Death*, 14 LAW, MED. & HEALTH CARE 141, 141 (1986).

⁵⁹⁵ *Id.*

⁵⁹⁶ *Id.*

⁵⁹⁷ See *id.*

⁵⁹⁸ *Id.*

⁵⁹⁹ See generally Comment, *A Structural Analysis of the Physician-Patient Rela-*

the physician must be allowed through maintenance of an option for her to transfer care of the terminal or at-risk patient.⁶⁰⁰

When courts are presented with a typical DNR case, they normally will balance the patient's qualified right to refuse treatment against two other factors: the prognosis for the patient and the degree to which the DNR order will be invasive to bodily integrity.⁶⁰¹ The state interest will yield to the individual privacy right as the prognosis for recovery lessens and the degree of bodily invasion increases.⁶⁰² Accordingly, when invasive treatment such as surgery or dialysis is dictated, the pervasive judicial attitude has been to uphold the patient's right to refuse treatment, even though there may well be a favorable patient prognosis.⁶⁰³ The few courts that have considered ONTRs have generally approved the orders given the high invasive nature of cardiopulmonary resuscitation.⁶⁰⁴

1. The 1976 Massachusetts General Hospital Protocol

In 1976 the Massachusetts General Hospital formally announced its protocol on "Optimum Care for Hopelessly Ill Patients."⁶⁰⁵ The first step of the directive set forth the process for determining the level of care which should be given to critically ill patients; namely, the classification of their probability of survivability or salvageability.⁶⁰⁶ Consistent with the time-honored principle of *triage*, four classifications are listed: Class A, when "maximal therapeutic effort without reserva-

tionship in No-Code Decisionmaking, 93 YALE L.J. 362 (1983) (criticizing current no-code decision making and urging replacement with system based on patient's informed consent).

⁶⁰⁰ See *id.*

⁶⁰¹ See, e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 664 (1976).

⁶⁰² See, e.g., *id.*

⁶⁰³ See, e.g., *Lane v. Candura*, 6 Mass. App. 377, 376 N.E.2d 1232 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978).

⁶⁰⁴ See, e.g., *Brophy v. New Eng. Sanai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Custody of a Minor*, 385 Mass. 697, 706-08, 709 n.9, 434 N.E.2d 601, 604-05, 607 n.9 (1982); *In re Dinnerstein*, 380 N.E. 2d 134, 135-36 (Mass. App. Div. 1978).

Some groups of chronically ill patients should be given the option of refusing treatment from the inception of that treatment. Knowing this option would particularly be re-assuring for unsophisticated individuals who might be unaware of it. See Appelbaum & Roth, *supra* note 274, at 1296; McKegney & Lange, *supra* note 274, at 267.

⁶⁰⁵ Massachusetts General Hospital, *Report of the Clinical Care Committee: Optimum Care for Hopelessly Ill Patients*, 295 NEW ENG. J. MED. 362 (1976) [hereafter *Clinical Care Committee Report*].

⁶⁰⁶ See *id.*; see also Rabkin, Gillerman & Rice, *supra* note 591, at 365.

tion"⁶⁰⁷ will be given; Class B, when the same level of effort is given, but "with daily evaluation because probability of survival is questionable";⁶⁰⁸ Class C, when "selective limitation of therapeutic measures"⁶⁰⁹ is followed (this class would normally include orders not to resuscitate or orders to withhold antibiotics); and Class D, "where all therapy can be discontinued,"⁶¹⁰ because the patient is either brain dead or has no chance of regaining "cognitive and sapient" functions.⁶¹¹ A permanent hospital committee on the optimum treatment of the hopelessly ill is in place in the event differences of opinion arise regarding treatment of a terminal patient. Thus, while the primary or "responsible physician" has full authority over the treatment of her patient — including the right not to seek the committee's advice at all or to reject it once given — the guidelines mitigate this full authority by allowing the director of intensive care to go directly to the chief of service and empanel the committee, regardless of whether the primary physician wishes to pursue this course.⁶¹² For obvious reasons, a physician would have to be particularly foolhardy or, in the alternative, courageous to act against the institutional judgment of his peers.

Institutional efforts of this nature present a model for effective and principled decision making. They also structure a verifiable process for evaluating the costs and benefits of treatment and nontreatment, thereby aiding not only the health care providers in their decision making, but also the family members or surrogate decision makers who must approve the ultimate decision.

2. The New York State Task Force on Life and the Law Statutory Proposal

In April 1986 the New York State Task Force on Life and the Law issued its study of ONTRs,⁶¹³ and proposed a model legislative scheme which was subsequently adopted by the legislature.⁶¹⁴ The statute not

⁶⁰⁷ *Clinical Care Committee Report*, *supra* note 605, at 362-63.

⁶⁰⁸ *Id.*

⁶⁰⁹ *Id.*

⁶¹⁰ *Id.*

⁶¹¹ *Id.*

⁶¹² *See id.*

⁶¹³ *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, PROPOSED LEGISLATION AND REPORT ON DO NOT RESUSCITATE ORDERS (1986) [hereafter NEW YORK TASK FORCE REPORT]. *See generally* Mooney, *Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 ILL. L. REV. 1025.

⁶¹⁴ The Proposed Legislation [hereafter Proposed Legislation], "Orders Not to Resuscitate," numbers twelve actual pages. *See* NEW YORK TASK FORCE REPORT, *supra*

only provides clear and comprehensive guidelines for decision making, but further establishes a strong mechanism for arbitration of challenges to decisions of this nature. The legislation embodies a number of major policies which are germane to the present issue and which go far toward clarifying the medico-legal use of an order not to resuscitate. Thus, an analysis of the legislation, itself, is necessary.

While affirming the existing presumption that all hospital patients consent to CPR in the event of cardiac or respiratory arrest, the legislation provides for consent for the withholding of CPR or the issuance of an order not to resuscitate in all hospitals and residential health care facilities in the State of New York.⁶¹⁵ Subject to a narrow therapeutic exception, an attending physician must obtain the consent of a patient with decisional authority prior to issuing a DNR order.⁶¹⁶ This decision by the patient in a hospital may be either expressed orally or in writing.⁶¹⁷

Before the issuance of a DNR order, the attending physician must first obtain the contemporaneous consent of a patient with decisional capacity.⁶¹⁸ If the at-risk patient lacks capacity at the time of issuing an order, but had previously stated her wish to forego CPR in writing, the writing will constitute consent to the issuance of the order.⁶¹⁹ Interestingly, the legislation wisely recognizes a narrow therapeutic exception which permits a physician to obtain consent to a DNR order from another person who acts on behalf of the patient.⁶²⁰ This exception is allowed since isolated circumstances may occur when a patient's capacity might be jeopardized and immediate injury occur from an actual dis-

note 613, at 59-71 (legislation on file with *U.C. Davis Law Review*). On August 7, 1987, Governor Mario Cuomo signed into law Chapter 818 of the Laws of New York, that adopted in major part the *Report's* findings and legislative proposals. The legislation became effective April 1, 1988, and was codified as Sections 2960-2978 of the New York Public Health Law. For a comparison of the new law with the proposals of the New York State Task Force on Life and the Law, see Comment, *Do Not Resuscitate Orders: A Matter of Life or Death in New York*, 4 J. CONTEMP. HEALTH L. & POL'Y 449 (1988).

⁶¹⁵ See N.Y. PUB. HEALTH LAW § 2962 (McKinney 1987) (Proposed Legislation §§ 2(6), 3, 4). The primary citation is the official codified citation of the Task Force Proposed Legislation. The parallel Proposed Legislation sections are included to facilitate comparison.

⁶¹⁶ *Id.* § 2964 (Proposed Legislation § 5).

⁶¹⁷ *Id.* § 2964(2)(a)(b) (Proposed Legislation § 4).

⁶¹⁸ *Id.* § 2964 (Proposed Legislation § 5).

⁶¹⁹ *Id.* § 2964(2)(b).

⁶²⁰ See *id.* § 2964 (3) (Proposed Legislation § 5(3)).

cussion about resuscitation.⁶²¹ Although injury is not defined, the Task Force cited two examples of situations when discussion would be inadvisable: (1) when a patient has an arrhythmia and a discussion could trigger cardiac arrest; or (2) when a patient is in a severe state of paranoid depression or has suicidal tendencies.⁶²²

Unless it is determined that an adult patient lacks capacity — not competence — to make a resuscitation decision, the presumption is maintained that every adult is entitled to make such a decision.⁶²³ The “competence standard” defines an individual’s ability to make all decisions, while the “capacity standard” assesses one’s ability to make a specific decision about resuscitation.⁶²⁴ When a patient lacks capacity to make a decision of this type, the attending physician is required to obtain the necessary consent from a surrogate.⁶²⁵ In this instance, the substitute decision maker must be available as well as willing and competent to speak for the patient.⁶²⁶ Provision is made for patients with capacity to designate an individual to act for and on their behalf if they are expected to lack capacity at the time the decision must be made.⁶²⁷

One of four medical conditions must exist and a written determination made by a physician before a surrogate decision maker may consent to the issuance of a DNR order.⁶²⁸ The four conditions are finding that: (1) the patient is terminally ill; (2) irreversibly comatose or permanently unconscious; (3) medically futile; and (4) resuscitation would impose an extraordinary burden on the patient in light of the patient’s medical condition or the expected outcome of resuscitation.⁶²⁹ The surrogate must base any decision on the patient’s known wishes or religious and moral beliefs.⁶³⁰ If these wishes or beliefs are either unknown or not ascertainable, the decision will be based on the patient’s best interests.⁶³¹

In those cases when a patient lacks capacity to make a DNR decision and a proper surrogate is unavailable, an order not to resuscitate can still be given if one of two conditions is met: (1) a determination is

⁶²¹ *See id.*

⁶²² *See id.*

⁶²³ *Id.* § 2962(1) (Proposed Legislation §§ 3 to 5).

⁶²⁴ *See id.* § 2961(3) (Proposed Legislation § 5).

⁶²⁵ *See id.* § 2965 (Proposed Legislation § 6).

⁶²⁶ *Id.*

⁶²⁷ *See id.* § 2965(2)-(3).

⁶²⁸ *See id.* § 2965(5)(c).

⁶²⁹ *Id.*

⁶³⁰ *Id.* § 2965 (5)(a) (Proposed Legislation § 6(5)).

⁶³¹ *Id.*

made by two physicians that it would be medically futile to undertake the act; or, (2) a determination is made based on clear and convincing evidence of either the patient's known wishes or in the absence thereof, a finding of the patient's best interests, to issue a court order for a DNR order.⁶³²

Before issuing a DNR order for a minor, the attending physician must first obtain the consent of such a minor's parent or legal guardian.⁶³³ However, if the attending physician, in consultation with the parents of the at-risk minor, determines that the minor does have decisional capacity, the minor's consent to the issuance of a DNR order must be obtained.⁶³⁴

The consent to the issuance of a DNR order is narrow and confined only to cardiopulmonary resuscitation; it *does not* authorize an extension of consent to withhold or withdraw medical treatment.⁶³⁵ The legislation also establishes a procedure for revoking a DNR order; the patient must make a written or oral declaration "or by any other act evidencing a specific intent to revoke such consent or assent" to a physician or to a nurse at the treating hospital.⁶³⁶ For the surrogate, parent or legal guardian, a similar procedure for revocation is provided.⁶³⁷ Once the revocation of consent is obtained, it is entered immediately in the patient's chart and notification given to the hospital staff.⁶³⁸

Section 13 of this legislation mandates that all hospitals and residential health care facilities establish a dispute mediation system in which all disagreements incident to the resuscitation decision may be aired.⁶³⁹ The mediation system allows *any* party to the controversy to come before it.⁶⁴⁰ If the matter is not resolved in mediation, the statute reserves to all parties the right to seek judicial relief.⁶⁴¹ Once a dispute is brought before the mediation service, the issuance of a DNR is automatically stayed for either seventy-two hours or until the conclusion of the mediation process, whichever occurs first.⁶⁴²

Judicial review of actions allowed under the legislation may essen-

⁶³² *Id.* § 2966(1) (Proposed Legislation § 7).

⁶³³ *Id.* § 2967 (2)(a) (Proposed Legislation § 8).

⁶³⁴ *Id.* (Proposed Legislation § 8).

⁶³⁵ *See id.* § 2968 (Proposed Legislation § 9).

⁶³⁶ *Id.* § 2969(1) (Proposed Legislation § 10).

⁶³⁷ *See id.* § 2969(2).

⁶³⁸ *Id.* § 2969(3).

⁶³⁹ *Id.* § 2972(3) (Proposed Legislation § 13).

⁶⁴⁰ *Id.*

⁶⁴¹ *Id.*

⁶⁴² *Id.*

tially be sought by the patient, attending physician, hospital, facility director if the patient was transferred, any personal surrogate, parents, or noncustodial parent or legal guardian of a minor patient.⁶⁴³ Even though the statute provides for a required grace period of seventy-two hours, the actual patient is not required to observe this period, and "may commence action for relief with respect to any dispute under this article at any time."⁶⁴⁴

For the physicians and other health care providers who comply in good faith with a DNR order, or who act in the good faith belief that an order has either not been issued or has been revoked, the legislation grants immunity from both civil and criminal liability.⁶⁴⁵ Equal protection from liability is also extended to persons designated to act for the patient who consent or decline to consent in good faith to the issuance of a DNR order.⁶⁴⁶ Finally, the legislation stipulates that no life insurance policy will be impaired or invalidated as a consequence of a DNR order, nor can any person require or prohibit the issuance of a DNR order as either a condition for being insured or for receiving health care services.⁶⁴⁷

To date, this proposal is the most balanced and comprehensive effort to define, strengthen, and stabilize the rights, authority, and protections afforded not only the at-risk patient, but also her family, surrogate decision makers, and health care providers, who all participate in the issuance of orders not to resuscitate. It provides a vital structure for principle decision making, a blueprint for subsequent state response, and a framework for achieving a national construct for response to this most critical area of contemporary medico-legal concern.

3. Unresolved Questions

In the continued development and application of DNRs, a number of unresolved questions may be posited: (1) Will new and more effective procedures be developed that will directly involve patients in do not resuscitate orders *before* they become moribund?; (2) Will prognosticative techniques advance to the point at which patients needing resuscitation will be identified with a certainty instead of the current practice

⁶⁴³ *Id.* § 2973(1) (Proposed Legislation § 14).

⁶⁴⁴ *Id.* § 2973(3) (Proposed Legislation § 14(2)).

⁶⁴⁵ *See id.* § 2974 (Proposed Legislation § 15); *see also* Oddi, *supra* note 556, at 641 (proposing new civil action to compensate patients whose right to die is interfered with by prolonged medical treatment).

⁶⁴⁶ *See* N.Y. PUBLIC HEALTH LAW § 2974(3) (McKinney 1987).

⁶⁴⁷ *See id.* § 2975 (Proposed Legislation § 16).

which identifies at-risk patients in vague categorical terms?; (3) Since current studies show cancer — instead of cardiac disease and old age — as the most likely predictor of DNR status, does this represent a danger-point in subsequent efforts that might bias or predispose the issuance of a DNR order?; (4) What should be done with meeting the demands of families who insist that all measure of life-sustaining treatment be done for the moribund patient, when that patient has never expressed herself on the issue?; (5) Should concern be raised that as a consequence of anticipated greater specificity and detail for DNR policies at hospitals, broader categories of nontreatment decisions might become acceptable?; (6) How far should health costs and the need to ration expensive and scarce interventions be considered in issuing DNRs?⁶⁴⁸

The complicated and often competing vectors of force or dynamics in nontreatment decisions must be understood and dealt with. Understanding these dynamics is surely no simple task in a pluralistic society in which a high level of consciousness exists regarding health care.⁶⁴⁹ The courts can only go as far as, and with as much clarity as, the information base which is provided by the medical profession. Of course, the judiciary should ideally not even intrude into the doctor-patient or familial sphere of decision making privacy. Perhaps this is too much to expect, given the vast amount of confusion regarding the “science” of orders not to resuscitate. The medical profession has everything to gain from efforts to control itself and define the parameters of its actions. Its input into legislative proposals such as the New York Study are laudable efforts to bring clarity and structure to this area of concern, thereby hopefully preventing judicial intrusiveness.

B. The American Medical Association's Guidelines for Withholding or Withdrawing Life Prolonging Medical Treatment

When Americans died in 1950, the majority died at home with their families and local physicians in attendance.⁶⁵⁰ Today, death has become “medicalized,” with the result that human interventions replace natural processes, thereby prolonging life in one form or other.⁶⁵¹ With a growing array of high-powered life support techniques and so-called

⁶⁴⁸ Youngner, *Do-Not-Resuscitate Orders: No Longer Secret, But Still a Problem*, HASTINGS CENTER REP., Feb. 1987, at 24, 32.

⁶⁴⁹ See *id.* at 33.

⁶⁵⁰ Malcolm, *Reassessing Care of Dying: Policy Seen Evolving from A.M.A. Opinion*, N.Y. Times, Mar. 17, 1986, at 1, col. 1.

⁶⁵¹ See Capron, *supra* note 594, at 141.

"miracle" drugs, death is simply another matter of human choice and one laden with ethical complexities.⁶⁵² Presently, of the approximately 5,500 Americans who die each day, 80% do so "wired and incubated in an institution where the expensive technology is arrayed and controlled by specialists who likely know little about the patient beyond the medical problem."⁶⁵³ Perhaps in recognition of this phenomena, a 1985 Louis Harris poll of 1,254 adults disclosed that 85% of them believed that a terminally ill patient "ought to be able to tell his doctor to let him die."⁶⁵⁴ Eighty-two percent supported the notion of withdrawing nasogastric (feeding) tubes if the at-risk patient directs such action.⁶⁵⁵

A poll sponsored by the American Medical Association, the results of which were released November 28, 1986, showed that nearly 3 of 4 Americans or 73% of the 1,510 respondents in this survey, favor "withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their family request it."⁶⁵⁶ Fifteen percent of the respondents opposed this option, and 12% expressed uncertainty.⁶⁵⁷ Interestingly, 75% of those younger than sixty-five favored the proposal, as did 64% of those sixty-five or older.⁶⁵⁸ Twenty percent of the older group said they were unsure — compared with 10% of the younger group.⁶⁵⁹ The withdrawal of life support systems was more likely to be favored by individual respondents having at least a high school education as well as by those respondents whose annual income was more than \$10,000.⁶⁶⁰

On March 15, 1986, the Council on Ethical and Judicial Affairs of The American Medical Association issued *Guidelines for Withholding*

⁶⁵² *Id.*

⁶⁵³ Malcolm, *supra* note 650, at 1, col. 1.

⁶⁵⁴ Wallis, *To Feed or Not to Feed*, TIME, Mar. 31, 1986, at 60

⁶⁵⁵ See *id.*; see also Cohn, *Doctor and Patient, Facing Death Together*, Wash. Post Health Mag., Mar. 15, 1988, at 14, col. 1.

⁶⁵⁶ American Med. News, Nov. 28, 1986, at 13, col. 1. In a new Gallup telephone survey of 509 lawyers conducted for the *ABA Journal* March 17-24, 56.8% stated that administering a lethal injection to a terminally-ill patient who wants to die *and* has made clear this wish, should be recognized as being legal. See Reidinger, *supra* note 459, at 38. A nearly equal percentage of attorneys, 57.6%, oppose legal euthanasia if the patient is incompetent and consent is obtained from her legal representative. *Id.* In these cases only 27.2% of the lawyers interviewed would approve of active euthanasia. Nine out of 10 lawyers (89.2%) in the survey agreed that active euthanasia should not be legal if the patient's consent is ambiguous. *Id.*

⁶⁵⁷ American Med. News, *supra* note 656, at 13, col. 1.

⁶⁵⁸ *Id.*

⁶⁵⁹ *Id.*

⁶⁶⁰ *Id.*

or *Withdrawing Life Prolonging Medical Treatment* for terminally ill or irreversibly comatose patients.⁶⁶¹ In essence, the guidelines recognize that a physician may ethically withdraw "all means of life-prolonging medical treatment,"⁶⁶² including food and water, from patients who are terminally ill or who are in irreversible comas.⁶⁶³ This policy statement is consistent with the conclusion of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research that artificial feeding should be regarded as a treatment decision and not mandated except when the benefits of the treatment outweigh the burdens.⁶⁶⁴

Many individuals choose to make an emotional distinction between respirators and feeding tubes even though both are means of life support for comatose patients.⁶⁶⁵ A number of people perceive an intravenous line as not only more familiar than an artificial respirator but also less intrusive.⁶⁶⁶ Interestingly, in the most distinguished case involving withholding medical treatment, *In re Quinlan*,⁶⁶⁷ Karen Ann Quinlan's family maintained a successful legal action to disconnect her artificial respirator.⁶⁶⁸ However, they did not seek judicial approval of a with-

⁶⁶¹ See Malcolm, *supra* note 650, at 1, col. 1; Wallis, *supra* note 654, at 60.

⁶⁶² Malcolm, *supra* note 650, at 1, col. 1.

⁶⁶³ See *id.* The AMA had previously acknowledged that "[w]here a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued," but also acknowledged that most patients of this nature were "probably given such measures as basic hygiene and artificial nutrition." 1982 A.M.A. Judicial Council Current Opinions 9-10, in PRESIDENT'S COMMISSION, *supra* note 386, at 186, 187; see also Colburn, *Withholding Food*, Wash. Post Health Mag., Jan. 26, 1988, at 15, col. 1.

⁶⁶⁴ See Lynn & Childress, *Must Patients Always be Given Food and Water?*, HASTINGS CENTER REP., Oct. 1983, at 17, 20; cf. PRESIDENT'S COMMISSION, *supra* note 386, at 90, 288.

Dr. Eugene Robin of Stanford University has observed that, "The ultimate judgment" to withhold or withdraw treatment "is not fundamentally a technical or medical matter," and "is not within the doctor's province. . . . The final answer can be found only in the human heart and can be determined only on an individual basis." Cohn, *The Right to Die: How Courts Have Ruled*, Wash. Post Health Mag., Mar. 22, 1988, at 8, col. 1.

⁶⁶⁵ See Annas, *Do Feeding Tubes Have More Rights than Patients*, HASTINGS CENTER REP., Feb. 1986, at 26, 26-28.

⁶⁶⁶ See Colburn, *AMA Ethics Panel Revises Rules on Withholding Food*, Wash. Post Health Mag., April 2, 1986, at 9, col. 1.

⁶⁶⁷ 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

⁶⁶⁸ See *id.*

drawal of Karen's nutritional support,⁶⁶⁹ and she "lived" for ten years in a coma.

While the withdrawal of nutritional support from a terminally ill or irreversibly comatose patient may move dangerously close to murder,⁶⁷⁰ the AMA statement specifically declares that "the physicians should not intentionally cause death."⁶⁷¹ Since the Council position is no way binding, physicians who disagree with it are free to follow the dictates of their own conscience.⁶⁷²

Dr. Russell H. Patterson, Jr., Chairman of Neurosurgery at the New York University-Cornell Medical Center and a past president of the American Association of Neurological Surgeons, suggests that there is "a rather large jump between letting someone die and killing someone."⁶⁷³ He argues that withdrawing extraordinary life supports from those who have no hope of ever regaining consciousness is often the most humane treatment available.⁶⁷⁴ He states: "After a while — maybe weeks or months of seeing the patient with no concept of the present, no memory of the past and no hope for the future — a lot of families say, 'Why does this have to go on? What's the purpose?'"⁶⁷⁵

The AMA policy acknowledges that while the physicians' social commitment is both to sustain life and to relieve suffering, these duties may often conflict. When an at-risk patient's informed choice is lacking or an authorized proxy unavailable, "the physician must act in the best interest of the patient."⁶⁷⁶ When acting humanely and with informed consent, a physician undertakes a medically necessary course of action "to alleviate severe pain, or cease or limit treatment to permit a terminally ill patient whose death is imminent to die."⁶⁷⁷ She should not follow a course of action that intentionally causes death.

In deciding whether the administration of potentially life-prolonging

⁶⁶⁹ See *id.*

⁶⁷⁰ See Annas, *supra* note 665.

⁶⁷¹ Wallis, *supra* note 654, at 60; see also Somerville, "Should the Grandparents Die": Allocation of Medical Resources with an Aging Population, 14 LAW, MED. & HEALTH CARE 158 (1986) (suggesting that AMA Guidelines may soon exclude "severely senile, the very old and decrepit, and . . . young profoundly retarded children" from medical support).

⁶⁷² See *id.*

⁶⁷³ Colburn, *supra* note 666, at 9, col. 3.

⁶⁷⁴ *Id.*

⁶⁷⁵ *Id.*; see Cohn, *A Safe Passage to Death*, Wash. Post Health Mag., Mar. 8, 1988, at 8, col. 1.

⁶⁷⁶ Statement of the Council on Ethical and Judicial Affairs, American Med. Ass'n, *Withholding or Withdrawing Life Prolonging Medical Treatment* (Mar. 15, 1986).

⁶⁷⁷ *Id.*

medical treatment comports with the incompetent patient's best interests, the physician must determine whether the possibility exists for extending life under both humane and comfortable conditions. Furthermore, she must ascertain the patient's previously expressed wishes and the familial attitudes of others who have custodial responsibility for the patient.⁶⁷⁸ The AMA adds:

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment. . . . In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.⁶⁷⁹

1. Past Practices

At the Yale-New Haven Hospital Symposium on "Ethical Issues in Health Care" in June 1982, Dr. Paul B. Besson, the Editor of the *Journal of the American Geriatrics Society*, cautioned that there was a growing tendency in hospitals throughout the country to place "no-code" orders on the hospital charts of a growing number of elderly patients.⁶⁸⁰ Several years before Dr. Besson revealed his findings, a 1973 Seattle study of nine convalescent centers, which examined the records of 1,256 persons admitted to these centers over a two-year period, revealed some rather startling statistics.⁶⁸¹

Over the period studied, 190 patients developed a high or continuing fever at some time or had an impairment of their central nervous system (e.g., stroke, aphasia, paralysis, senility, dementia, chronic or organic brain syndrome, and cerebral atheroarteriosclerosis).⁶⁸² Active treatment — or the use of antibiotics or hospitalization or both — was ordered for only 109 patients.⁶⁸³ No such treatment was ordered or administered for 81 patients, or more than 40% of patients.⁶⁸⁴ Of those treated, 9% died.⁶⁸⁵ Of those untreated, 59% died.⁶⁸⁶ The authors of the

⁶⁷⁸ *Id.*

⁶⁷⁹ *Id.*

⁶⁸⁰ *Doctor Sees Trend Not to Resuscitate*, Wash. Post, June 13, 1982, at A1, col. 3.

⁶⁸¹ See Brown & Thompson, *Nontreatment of Fever in Extended-Care Facilities*, 300 NEW ENG. J. MED. 1246 (1979).

⁶⁸² *Id.*

⁶⁸³ *Id.*

⁶⁸⁴ *Id.*

⁶⁸⁵ *Id.*

study conclude that this obvious pattern of nontreatment strongly suggests that the physicians and nurses at these medical facilities did not intend actively to treat their patients when high mortality was expected.⁶⁸⁷ The lives of the untreated patients could have been prolonged for a short time if antibiotics had been administered or hospitalization followed.⁶⁸⁸ The general conclusions of this study complement other surveys of health professionals favorably disposed to withdrawing or withholding life-prolonging treatment to terminally ill patients — with as many as 30% favoring euthanasia under certain prescribed conditions.⁶⁸⁹

In 1979 the Veterans Administration, which administers the largest hospital system in the nation with 1.2 million annual patient admissions, prohibited entering “no-code” or do not resuscitate orders on a patient’s medical chart.⁶⁹⁰ In late August the Administration promulgated a new policy which recognizes a patient’s right to die and now allows “no-code” decisions to be written in a patient’s chart.⁶⁹¹ Pursuant to the new policy, “no-code” decisions must be made by a senior physician with the permission of the at-risk patient.⁶⁹² When the pa-

⁶⁸⁶ *Id.*

⁶⁸⁷ *See id.*

⁶⁸⁸ *See id.*

⁶⁸⁹ *See D. CRANE, THE SANCTITY OF SOCIAL LIFE: PHYSICIAN’S TREATMENT OF CRITICALLY ILL PATIENTS* 58-61 (1975); Noyes, Jochimsen & Travis, *The Changing Attitudes of Physicians Toward Prolonging Life*, 25 J. AM. GERIATRIC SOC’Y 470 (1977).

A recent article studied patients (and their family support groups) who were admitted for at least 24 hours to the medical or respiratory intensive care units at North Carolina Memorial Hospital in Chapel Hill, between January 1-December 31, 1983. *See* Danis, Patrick, Southerland & Green, *Patients’ and Families Preferences for Medical Intensive Care*, 260 J. A.M.A. 797 (1988). The study indicated that 70% of patients and families were 100% willing to undergo intensive care again to achieve one month of survival. *Id.* This willingness was regardless of their age, functional status, perceived quality of life, hypothetical life expectancy, or the nature of their previous intensive care unit experiences. *Id.* Eight percent were, however, completely unwilling to undergo intensive care to achieve any prolongation of survival. *Id.* Thirty-eight percent of the patients and 41% of the patients’ families in the survey reported that the circumstances under which they would refuse to repeat intensive care are: when no hope of recovery exists, when severe neurologic impairment exists, and when being kept alive by machine. Zweibel, *Measuring Quality of Life Near the End of Life*, 260 J. A.M.A. 839 (1988). This study points dramatically to the need for a more focused measure of quality of life for research on end-of-life treatment preferences. *See id.*

⁶⁹⁰ *See* Weiner, *New VA Policy Allows Right-to-Die Instructions*, Wash. Post, Sept. 20, 1983, at 1, col. 1.

⁶⁹¹ *See id.*

⁶⁹² *Id.*

tient is adjudged legally incompetent, the family must consent before a no-code order may be entered on the hospital records.⁶⁹³ While the policy expressly prohibits using no-code orders to accommodate a patient's request for "voluntary euthanasia," and forbids physicians to "take any affirmative steps to 'hasten the patient on his/her way,'" ⁶⁹⁴ in actuality, the policy validates passive euthanasia or letting die.⁶⁹⁵ Application of the 1979 Veterans Administration Policy simply meant that if a physician chose to respect the request or right of a patient to forego futile life-saving therapy, the physician's decision could not formally be entered in the patient's hospital chart. Accordingly, in cases when a patient suffered cardiac arrest and her attending physician was not on duty, resuscitation would normally be undertaken against the patient's wishes.

The new AMA policy incorporates an obvious quality of life standard of evaluation by utilizing "the best interests of the patient" test and by mandating a cost-benefit analysis.⁶⁹⁶ Basic social justice demands that each individual be given an opportunity to maximize her individual potential. Yet, the point is often reached when maintenance of an individual defies all concepts of social justice and basic humanitarianism. When an individual's medical condition represents a negation of any "truly human" qualities or "relational-potential," then the best and most equitable form of treatment should be no treatment at all.⁶⁹⁷ In the final analysis, common sense and common decency should be the touchstones for decision making.

These policies of the American Medical Association ⁶⁹⁸ and the Veterans Administration,⁶⁹⁹ which recognize the patient's right to die humanely and with dignity, supported by the actual evidence of selective nontreatment of the terminally ill,⁷⁰⁰ illustrate that intelligent health care providers are exercising common sense, common decency, love, and compassion in their actions.⁷⁰¹ They are not bridled by complicated and obtuse distinctions between ordinary and extraordinary treatment standards, acts of commission and omission, and a plethora of

⁶⁹³ *Id.*

⁶⁹⁴ *Id.*

⁶⁹⁵ *See id.* *See generally* Kuhse, *supra* note 28, at 125.

⁶⁹⁶ *See* Cohen, *Ethical Problems of Intensive Care*, 47 *ANESTHESIOLOGY* 217 (1977); Smith, *supra* note 501, at 143; Smith, *supra* note 350, at 709.

⁶⁹⁷ *See* McCormick, *supra* note 350, at 349.

⁶⁹⁸ *See supra* notes 676-79 and accompanying text.

⁶⁹⁹ *See supra* notes 690-95 and accompanying text.

⁷⁰⁰ *See supra* note 689 and accompanying text.

⁷⁰¹ *See* Fletcher, *Love is the Only Measure*, 83 *COMMONWEALTH* 427 (1966).

philosophical concerns over slippery slopes. Rather, they act courageously and forthrightly; when motivated by the age-old command to do no harm, they serve the best interests of their patients.⁷⁰²

2. Other Official Postures

In 1983 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that artificial feeding should be regarded as a treatment decision and not mandated except when the benefits of its use outweigh the burdens.⁷⁰³ As mentioned previously, in 1986 the American Medical Association's Council on Ethical and Judicial Affairs announced its conclusion that all means of life-prolonging *treatment* — including food as well as water — could be withdrawn from patients in an irreversible state or those in a terminal condition.⁷⁰⁴

The Roman Catholic Church takes the position that under some exceptional circumstances providing nourishment may not be obligatory because of the ineffective or burdensome nature of the act.⁷⁰⁵ Thus, the withholding of nutrition and hydration does not have as its purpose the hastening of death but rather the cessation of a life from which the patient can derive no benefit because of her futile or terminal condition.⁷⁰⁶ With but one exception, the prominent Catholic theologians are of one mind: nutrition and fluids need not always "be provided to all patients, including the terminally ill."⁷⁰⁷

Even though a judicially determined order to withdraw life-sustaining treatment does not overtly affront the integrity of the corporate hospital in which the terminal patient might be, some health providers may nevertheless view the court order as an intolerable compromise or invasion of their own personal professional rights as physicians and

⁷⁰² See G. SMITH, *supra* note 31, at 2, 8, 164.

⁷⁰³ See PRESIDENT'S COMMISSION, *supra* note 386, at 288.

⁷⁰⁴ See Wallis, *supra* note 654, at 60. More recently, the Maryland Attorney General stated that permanently unconscious patients have a constitutional and common-law right to die with dignity by refusing life sustaining treatment, which includes artificially administered nutrients and liquids. 73 Op. Att'y Gen. 88-046 (1988). This position conflicts with the position of the Roman Catholic Archbishop of Baltimore who labels the acts of withdrawal as homicide. Valentine, *Md. Offers Guidance on Euthanasia*, Wash. Post, Oct. 18, 1988, at B1, col. 1.

⁷⁰⁵ See Paris & McCormick, *supra* note 33, at 358.

⁷⁰⁶ See *id.*

⁷⁰⁷ *Id.* at 361. See generally D. KELLY, *THE EMERGENCE OF ROMAN CATHOLIC MEDICAL ETHICS IN NORTH AMERICA* (1979).

nurses as using their skills to promote death.⁷⁰⁸ In cases of this nature, the dying patient should be transferred to another hospital willing to cease all artificial life supports.⁷⁰⁹ When transfers are not feasible because of costs and/or unavailable beds in other hospitals, the issue becomes whether care of a dying patient can be undertaken at home. Because of an unmistakable perception of pain because of the patient's marked change of appearance resulting from the withdrawal of fluids and nutrition, coping with at-home care can be difficult to manage.⁷¹⁰ Thus, what might be initially thought of as a rather simple decision to withdraw treatment becomes very complex since the decision affects more than the dying patient.

An artful act of self-deception has been used in the past to deal with this issue and continues in use today.⁷¹¹ This deception consists of continuing the intravenous feeding of a critically ill patient but at a diminished rate, so that over time, the patient becomes dehydrated. Thus, both the gesture and *symbol* of feeding is maintained, but at a rate that will not really sustain the patient's life for any period of time. Considered a "compromise" by those who wish to show a modicum of respect for the patient's direct wishes or perceived needs under a substituted judgment test, this procedure is simply a blatant act of self-deception, "because an agent can carry it out only by failing to acknowledge that the patient will become malnourished and dehydrated while the IV line maintains the fiction and expresses the symbol of feeding. Otherwise the agent would have to take responsibility for the outcome. . . ."⁷¹²

The courts must also confront this issue in deciding "whether the corporate hospital should be required to provide services for its patients that the profession deems ethical and the courts hold to be lawful."⁷¹³ The modern hospital must be recognized, institutionally, as the final rite of passage, regardless of whatever standard of care and treatment can be provided.⁷¹⁴

Probably the overriding purpose of health law is to support medical and nursing care where the patient's wishes and best interest coincide. The coincidence of autonomy and appropriate health care is very clearly present when a competent judgment or substitute judgment is made allowing

⁷⁰⁸ See Gostin, *The Right to Choose Death: The Judicial Trilogy of Brophy, Bouvia, and Conroy*, 14 LAW, MED. & HEALTH CARE 198, 201 (1986).

⁷⁰⁹ See *id.* at 200.

⁷¹⁰ See *id.*

⁷¹¹ See Childress, *supra* note 506, at 81.

⁷¹² *Id.* at 81; see Hilfiker, *supra* note 505, at 716.

⁷¹³ Gostin, *supra* note 708, at 201.

⁷¹⁴ See *id.*

a patient to spend his or her final brief moments of life in the health care setting that has been humanely treating and caring for the patient.⁷¹⁵

When conscious awareness is lost and not capable of being re-established, and all aspects of comfortable existence are removed as well, actions that omit nourishment by tubes are not subterfuges for euthanasia, but merely good medicine.⁷¹⁶

3. The Hastings Center *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*

In issuing its *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* in 1987, the prestigious Hastings Center of New York set a new tone of acceptance and understanding in this area of concern.⁷¹⁷ Consistent with the newly enacted Do Not Resuscitate Order Legislation in New York State,⁷¹⁸ the *Guidelines* offer an ethical framework for analyzing problem cases involving long-term life-supporting technology, ventilators and dialysis,⁷¹⁹ emergency interventions (e.g., cardiopulmonary resuscitation),⁷²⁰ nutrition and hydration of terminal patients,⁷²¹ antibiotics and other life-sustaining medication,⁷²² and palliative care and pain relief.⁷²³

Four central values form the foundation of the Hastings Center *Guidelines*: (1) medicine should always promote the patient's well-being or welfare; (2) the patient should possess absolute autonomy or self-determination when determining the nature of her own medical care; (3) the integrity of health care professionals must be guaranteed by recognizing the stringent ethical obligations which physicians, nurses, and other health care providers have to their patients; and (4) the importance of justice and equity in critical decisions of termination of treatment — in other words, the individual patient's right to access an adequate level of health care as well as to distribute available health

⁷¹⁵ *Id.*

⁷¹⁶ See Williamson, *Prolongation of Life or Prolonging the Act of Dying?*, 202 J. A.M.A. 162 (1967).

⁷¹⁷ See HASTINGS CENTER OF NEW YORK, *GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING* 46-52 (1987) [hereafter HASTINGS CENTER GUIDELINES].

⁷¹⁸ See *supra* notes 613-47 and accompanying text.

⁷¹⁹ See HASTINGS CENTER GUIDELINES, *supra* note 717, at 35-42.

⁷²⁰ See *id.* at 43-56.

⁷²¹ See *id.* at 57-62.

⁷²² See *id.* at 63-68.

⁷²³ See *id.* at 69-75.

care resources.⁷²⁴

The issue of costworthiness must also be considered as a value in decision making of this nature. Treatment that is wasteful, useless, or harmful is simply not costworthy.⁷²⁵

An ethic that aims to provide costworthy care cannot assume that any medical intervention that offers some benefit, no matter how marginal, should be provided regardless of its cost to others. Such an ethic must ask whether treatment that is marginally beneficial is cost worthy in light of some satisfactory balance between benefit to the individual patient and alternative uses of these resources.⁷²⁶

These policy statements will be indispensable to health care professionals and other decision makers who are called upon to make the ultimate treatment decisions. These policies should also assist the legislatures in responsibly designing frameworks, hopefully along the lines of the New York Do Not Resuscitate Model.

4. Age-Based Rationing of Health Care

The director of The Hastings Center, Dr. Daniel Callahan, authored a controversial book in 1987 entitled, *Setting Limits: Medical Goals in an Aging Society*,⁷²⁷ in which he introduces the principle of age-based rationing.⁷²⁸ He argues persuasively that a national policy should be introduced and implemented that prohibits the development or application of medical technologies that are designed or likely "to produce only chronic illness and a short life, increase the present burden of chronic illness,"⁷²⁹ or that extend the lives of the elderly yet "offer no significant improvement in the quality of life."⁷³⁰ The social policy which he advocates would limit life-extending treatment for the aged and could be implemented by denying Medicare benefits to various elderly groups.⁷³¹ In creating these groups, various factors, based upon quality of life standards, are used to determine when morally appropriate care can be withheld.⁷³²

⁷²⁴ See *id.* at 6-8.

⁷²⁵ See *id.* at 119-25.

⁷²⁶ *Id.* at 122. See generally Smith, *supra* note 501, at 143.

⁷²⁷ D. CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987).

⁷²⁸ See *id.* at 140. See generally Angelo, *Examining the Limits of Life*, TIME, Nov. 5, 1987, at 76.

⁷²⁹ D. CALLAGHAN, *supra* note 727, at 143.

⁷³⁰ *Id.*

⁷³¹ See *id.* at 198-99.

⁷³² See *id.* at 181-82.

The underlying tenet of the framework is that if no genuine benefit is conferred upon the patient by the medical assistance, and there is no meaningful life present, no life-prolonging actions should be undertaken.⁷³³ Accordingly, if medical treatment can morally be stopped, artificially provided food and water can and should be stopped.⁷³⁴ This later recognition is the most difficult to accept or "sell" because it goes against the great moral tradition of meeting a societal "duty" to feed the hungry and provide water to the thirsty.⁷³⁵

Dr. Callahan's arguments are indeed very persuasive. However, a strong inconsistency exists between the broad policy of age-based rationing — limiting health care for the elderly — and his refusal to accept the rights of self-determination of the elderly through the legalization of assisted suicide or euthanasia.

Fearing that such a policy "would serve as a threatening symbol of [the] devaluation of old age,"⁷³⁶ Callahan believes that there "might be" a significant number of elderly drawn to this newly-approved situation; they would interpret the action or its legalized condonation "as a societal concession to the view that old age can have no meaning and significance if accompanied by decline, pain and despair."⁷³⁷ For Callahan, legalization of assisted suicide would approach an official recognition "that pain is not to be endured, that community cannot be found for many of the old, and that a life not marked by good health, by hope and vitality, is not a life worth living."⁷³⁸ To base a denial of full rights of self-determination for the elderly on fears of what "might happen" demeans the whole value of autonomy and constricts its application to only "approved" or presently "legitimate" purposes. It is the *individual* — regardless of age or infirmity — who should make the final determinations about her health care or medical needs. What official state policy is promoted by maintaining one in a state of "endured"

⁷³³ See *id.* at 190. For individuals declared to be *brain dead*, no further care of any kind (medical or nursing) is directed. *Id.* at 182-83. For the *severely demented* it is inappropriate to terminate nursing care or either artificial or natural nutrition and hydration. *Id.* For those suffering a *mild impairment of competence*, advanced life supports are not morally required. *Id.* For the *severely ill, mentally alert patient*, nursing care should be provided; and finally, for the *physically frail, mentally alert patient*, extended intensive care and advanced life supports are unwarranted at public expense. *Id.*

⁷³⁴ See *id.* at 187, 191.

⁷³⁵ See *id.* at 188.

⁷³⁶ *Id.* at 196.

⁷³⁷ *Id.*

⁷³⁸ *Id.*

pain? Are community values preserved by condoning a continuation of such states of human existence? I think not.

5. Handicapped Newborns

The final rule of the Department of Health and Human Services promulgated on April 15, 1985, entitled, "Child Abuse and Neglect Prevention and Treatment Program,"⁷³⁹ formulates a specific set of regulations regarding the medical treatment of severely handicapped newborns in state hospitals that receive federal grant assistance.⁷⁴⁰ Withholding from infants medically indicated treatment, including "appropriate nutrition, hydration and medication," is prohibited.⁷⁴¹ Thus, little latitude is left for medical judgment regarding the treatment's advisability. The three circumstances when treatment is not required are when the infant is either chronically and irreversibly comatose, "the treatment would merely prolong dying" and "not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or [would] otherwise be futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane."⁷⁴²

Even though severely handicapped infants cannot express their preferences as to continuing or discontinuing their lives, their incapacity should not mandate medical therapy which would salvage or prolong their "lives" at the cost of significant suffering.⁷⁴³ "Where treatment

⁷³⁹ "Child Abuse and Neglect Prevention and Treatment Program," 45 C.F.R. § 1340 (1988).

⁷⁴⁰ See *id.*; see also Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (codified as amended at 42 U.S.C. §§ 701-709 (1982 & Supp. IV 1986)).

⁷⁴¹ 45 C.F.R. § 1340 (1988).

⁷⁴² *Id.* § 1340.15 (1988).

⁷⁴³ See generally H. KUHSE & P. SINGER, *SHOULD THE BABY LIVE?* (1986); Smith, *supra* note 350, at 709. A nontreatment policy for severely handicapped or defective infants might be more morally and socially acceptable if the decisions were made according to criteria "authoritatively articulated and publicly announced" and not dependent on whatever particular physicians and distressed families might decide. Robertson, *Substantive Criteria and Procedures in Withholding Care from Defective Newborns*, in *THE LAW MEDICINE RELATION: A PHILOSOPHICAL EXPLORATION* 217, 221-24 (S. Spicker, J. Healey, Jr. & H. Englehardt, Jr., eds. 1981). Second, such a policy might be more assured if the decision makers (*e.g.*, physicians and parents) adhering to the articulated criteria followed a "specific process for assuring that a given infant falls within the category of those who may justifiably be selected for non treatment." *Id.* The class of infants justifiably selected would be those "whose suffering is so great that continued life is not in their interest" or "whose conscious existence is so greatly limited that investing in their care appears to reasonable people to yield no benefits" (*e.g.*, when the infants are irreversibly comatose or when death is imminent). *Id.*

has a high probability of causing significant pain and suffering and a low probability of preserving a life valuable to the patient, should we not permit a decision to withhold it?⁷⁴⁴

The question raised in light of this government policy for handicapped newborns is whether a standard of aggressive treatment should be implemented and imposed on *all* incapacitated (e.g., incompetent) patients except when either death would occur in the near future or, alternatively, the patient is irreversibly comatose.⁷⁴⁵

Is it always in the best interest of the elderly senile patient with advanced cancer to receive chemotherapy or radiation therapy until he is highly unlikely to survive beyond the near future? Should the severely debilitated (but not comatose) stroke victim be resuscitated an indefinite number of times until respiration cannot be restored by any means? There comes a point at which further prolongation of one's life simply does not make up for the burden of continued aggressive treatment, especially if the quality of life prolonged is diminished by suffering and incapacity. If it would be cruel to prolong the life of adult patients under these circumstances, then it must also be cruel to prolong the life of handicapped infants under comparable circumstances.⁷⁴⁶

Although inhumane or cruel treatment deserves serious consideration, the other very practical issue is an economic one; namely the need to find health care resources to meet the needs of those receiving life-prolonging treatments. Cost-benefit analysis becomes a valid consideration in rationing scarce medical resources.⁷⁴⁷

⁷⁴⁴ Moskop & Saldanha, *The Baby Doe Rule: Still a Threat*, HASTINGS CENTER REP., Apr. 1986, at 8, 8-9.

⁷⁴⁵ See *id.* at 14.

⁷⁴⁶ *Id.*

⁷⁴⁷ See Donley, *A Brave New World of Health Care*, 2 J. CONTEMP. HEALTH L. & POL'Y 47, 51 (1986); Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 WIS. L. REV. 239; Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23 (1986); Sommerville, "Should the Grandparents Die?": Allocation of Medical Resources with an Aging Population, 14 LAW, MEDICINE & HEALTH CARE 158 (Sept. 1986); Smith, *supra* note 593, at 47, 49; Smith, *supra* note 501, at 143.

Most authors believe that terminally ill patients receive proportionately more expensive treatment than other patients and that the issue of extended care should consequently be made within the reasonable context of cost containment. Based upon these assumptions, a distinguished group of researchers has set three basic goals for cost containment policies of the terminally ill: (1) develop more reasonable criteria for admitting patients to intensive or critical care units; (2) promote the autonomy of patients and their families as decision makers in health care issues; and (3) further develop and thereby promote alternative forms of institutional care such as the hospice. Bayer, Callahan, Fletcher, Hodgson, Jennings, Monsees, Sievert & Veatch, *The Care of the Terminally Ill: Morality and Economics*, 309 NEW ENG. J. MED. 1490, 1491, 1493

The distinction drawn between defective newborns and critically ill adults is most alarming. Emotions and feelings run much higher; decisions are made within a vortex of emotionalism when they concern infants rather than adults and the elderly. Perhaps this distinction is because aspirations are higher for the young than for the old. In any event, decisions to withdraw or withhold treatment for both groups should be made when a cost-benefit analysis reveals that the costs of treatment outweigh the long-run benefits and ignore the patient's best interests.⁷⁴⁸

C. *The Legal Perspective*

1. A Right to Refuse Treatment?

The preservation or sanctity of life has always been an important state interest in the common law; in always holding life sacred, the common law prohibited a person from either committing suicide or permitting her own destruction.⁷⁴⁹ This general prohibition was equally applicable to those who were hopelessly ill as to those in good health.⁷⁵⁰ A number of early cases likened a patient's refusal of life-saving treatment to suicide. Accordingly, the state's interests in preserving the sanctity of life weighed against a patient's right to die with dignity.⁷⁵¹ Re-

(1983); see also Fries, *Aging, Natural Death and the Compression of Morbidity*, 303 NEW ENG. J. MED. 130, 131, 135 (1980). Fries predicts that the mean average age at death by the year 2000 will be 82.4 years. *Id.* at 131.

⁷⁴⁸ See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); PRESIDENT'S COMMISSION, *supra* note 386, at 5 & n.3, 228; see also Englehardt, *Ethical Issues in Aiding the Death of Young Children*, in BENEFICIENT EUTHANASIA 180, 187 (M. Kohl ed. 1975). Englehardt proposes a concept of injury for continuance of existence as an analogue of the tort of wrongful life. See *id.* He states: "It seems reasonable . . . that the life of children with diseases that involve pain and no hope of survival should not be prolonged." *Id.* at 189. See generally R. WEIR, *SELECTIVE NON TREATMENT OF HANDICAPPED NEWBORNS* (1984); Englehardt, *Euthanasia and Children: The Injury of Continued Existence*, 83 J. PEDIATRICS 170 (1973).

⁷⁴⁹ See Cantor & Conroy, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 549 (1985); *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1203.

⁷⁵⁰ See Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus*, 13 CREIGHTON L. REV. 795, 815 (1980).

⁷⁵¹ See, e.g., *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1009, *reh. en banc denied*, 331 F.2d 1010 (D.C. Cir. 1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 579-80, 279 A.2d 670, 672-74 (1971).

cent cases have tended to ignore the suicide analogy,⁷⁵² and some have failed to mention at all the state's interest in the sanctity of life.⁷⁵³ Moreover, the analogy to suicide is wholly inappropriate; popular perception normally views an act of suicide as a choice which recognizes the worthlessness of life, while the decision to decline life-saving medical measures is a choice that does not express a realization that life is worthless. Indeed, to decline treatment does not imply a rejection of life any more than other behavior which involves high risks to life and health. Similarly, the right to decline treatment does not imply a right to commit suicide.⁷⁵⁴

As a corollary to the state interest in the sanctity of life, the state also has a basic interest in preserving life, preventing suicide, protecting incompetents and third party defendants, as well as preserving the medical profession's integrity.⁷⁵⁵ Thus, in validating or invalidating a right to die by refusing medical treatment, the courts will balance the individual rights of self-determination or autonomy against these state interests. The nuances of this balancing depend entirely on the facts of each case; no unyielding *a priori* standard can be set and applied in an equally unyielding manner. Common sense and reasonable judgments are all that can be expected or actually made in tragic cases of this nature.⁷⁵⁶

The most significant state interest here is the preservation of life. Thus, the assertion or maintenance by the state of its interest depends on how "life" is defined. The state will always act to prevent "irrational self-destruction."⁷⁵⁷ Ultimately, the central question must address the appropriately structured guidelines available which could test the very rationality of decision making. What may seem reasonable to a legally competent but suffering patient may seem irrational to her attending physician. Sadly, in actual practice, the determination of a patient's right to die is essentially a judgment call.

⁷⁵² See, e.g., *Satz v. Perlmuter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985).

⁷⁵³ See, e.g., *In re Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976).

⁷⁵⁴ See 4 *ENCYCLOPEDIA OF BIOETHICS* 1502 (W. Reich ed. 1976).

⁷⁵⁵ See Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1, 35 *passim* (1975).

⁷⁵⁶ See *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (state's interest in preventing spread of smallpox held to supersede person's right to refuse treatment inoculation). See generally G. GRIEZ & J. BOYLE, JR., *supra* note 14.

⁷⁵⁷ *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 225 (1984).

Case precedent does recognize, however, that if compelled treatment will be brief and painful or extend life only as a consequence of great bodily intrusion, the "rationality" of original decision making by the patient will be given greater presumptive validity while at the same time minimizing the state's interest in preserving life.⁷⁵⁸ On the other hand, a state's interest would prevail when medical treatment preserves life rather than merely seeks to prolong it,⁷⁵⁹ produces little, if any, pain and suffering, and constitutes no significant bodily intrusion.⁷⁶⁰

For the terminally ill patient, the qualitative value of sustained life should not be an issue of great moment; rather, it should merely be conceded that the dying processes should not unduly be prolonged.⁷⁶¹ For the nonterminal but chronically ill, retarded, debilitated, or comatose patient, the state interest in preserving life is maintained if for no other reason than to protect such individuals from being eliminated. The state must protect the patient from herself when suffering depression, from physicians who need hospital bed-space, and from families who can no longer bear the social and economic costs of maintaining the patient's life.⁷⁶²

Of course, tests such as "the best interest of the patient," and "the substituted judgment test" allow a court to inquire into the extent state action may force a continuation of life in a terminal state. The length of one's life expectancy before it becomes affirmatively diagnosed as *terminal* is a vexatious issue. Should an individual suffering from AIDS, with an expected minimum of six years to live, be recognized as

⁷⁵⁸ See *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); see also *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 53-55, 355 A.2d 647, 665-68, *cert. denied sub nom.* *Garger v. New Jersey*, 429 U.S. 922 (1976); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

⁷⁵⁹ See *Saikewicz*, 373 Mass. at 737-40, 370 N.E. 2d at 423-24; *Quinlan*, 70 N.J. at 23-29, 355 A.2d at 655-57; *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *Eichner v. Dillon*, 72 A.D.2d 431, 468-69, 426 N.Y.S.2d 517, 545 (1980).

⁷⁶⁰ See *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (1978); see also *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

⁷⁶¹ See P. RAMSEY, *ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS* 1-14 (1978).

⁷⁶² See Sherlock, *For Everything There is a Season: The Right to Die in the United States*, 1982 B.Y.U. L. REV. 545, 560 (1982). While the principle of beneficence could arguably support a course of medical treatment against a patient's wishes, it is restricted or bounded by respect for persons or simply recognition of one's autonomy. This principle of personal respect mandates that full attention be given to the competency of the patient who disclaims using prolonged life-sustaining therapies. See J. CHILDRESS, *supra* note 22, at 175.

nonterminal and forced to live on by the state?⁷⁶³ It has been suggested that the closer one's "life expectancy is to zero, the more the condition becomes 'terminal' and the patient's interests" more determinative.⁷⁶⁴

While every competent person may assert a well-structured right to refuse medical treatment based on any reason, courts are now recognizing a coordinate right to avoid being declared incompetent as a consequence of that basic refusal.⁷⁶⁵ To date, the United States Supreme Court has not definitively ruled on whether an individual possesses a constitutional right to forego a modality of medical treatment calculated to save her life.⁷⁶⁶ Thus, care must be taken to recognize that other individuals may be empowered to determine when and if life supports are not necessary to maintain continued existence.⁷⁶⁷ After having litigated the issue, several prominent state jurisdictions have concluded that competents may assert a qualified right to refuse treatment.⁷⁶⁸

The validation of a qualified right to die⁷⁶⁹ is derived from several theories: the common law "right to bodily integrity,"⁷⁷⁰ a so-called penumbra "right of privacy,"⁷⁷¹ the first amendment right of "free exer-

⁷⁶³ See Comment, *Balancing the Right to Die with Competing Interests: A Socio-Legal Enigma*, 13 PEPPERDINE L. REV. 109, 127 (1985).

⁷⁶⁴ *Id.* at 126. For example, a patient might be classified as terminal because she is expected to live for nine months even though other significant variables exist: her treatment may be intrusive and painful, and she has expressed a desire to be removed from life-sustaining mechanisms to die in a more dignified manner. *Id.* at 123-24. Another scenario is a patient in a more terminal condition because she only has a five-month life expectancy: her treatment is less intrusive and thus less painful and, furthermore, her desire to be taken off life-supporting treatment has wavered. *Id.* In this latter case, the patient's condition would have to be more serious to meet or overcome the competing state interest in preserving life. *Id.* For a set of additional interesting hypotheticals, see *id.* at 125.

⁷⁶⁵ See R. VEATCH, *supra* note 439, at 146.

⁷⁶⁶ See J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 246, at 764.

⁷⁶⁷ See *id.*

⁷⁶⁸ See, e.g., *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

⁷⁶⁹ See Jonas, *The Right to Die*, HASTINGS CENTER REP., Aug. 1978, at 31.

⁷⁷⁰ See, e.g., *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *Conroy*, 98 N.J. at 348, 486 A.2d at 1222; ; *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 276, 438 N.Y.S.2d 266, 272, *cert. denied*, 454 U.S. 858 (1981); *In re Colyer*, 99 Wash. 2d 114, 132-33, 660 P.2d 738, 743 (1983).

⁷⁷¹ See, e.g., *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739-41, 370 N.E.2d 417, 425-27 (1977); *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663, *cert. denied sub nom.* *Garger v. New Jersey*, 429 U.S. 922 (1976); *Storar*, 52 N.Y.2d at 363, 420 N.E.2d at 64, 438 N.Y.S.2d at 266.

In *In re Yetter*, 62 Pa. D. & C.2d 619 (1973), the court held, that "the right of

cise of religion,"⁷⁷² and to a growing extent, state natural death legislation.⁷⁷³ The right to refuse medical treatment has recently been recognized as a "newly created constitutional right of personal autonomy."⁷⁷⁴ Current trends suggest that a refusal-of-treatment decision should be as informed as the initiating consent to it.⁷⁷⁵ Indeed, the doctrine of informed refusal is an inherent part of the doctrine of informed consent.⁷⁷⁶

2. A Detailed Analysis of Leading Case Precedents

Surely, almost every week in some city, either a competent individual or one lacking in capacity, who is afflicted with an irreversible health condition that classifies her as terminal, makes the decision not to prolong her life. Some of these cases are reported by the local news, while others are in lower courts without official published records. However, more and more cases find their way to appellate tribunals. It is neither the intention nor the purpose of this Article to survey and analyze all of these cases. Rather, discussion of a number of the early and new paradigmatic "landmarks" is in order to place the ethical, philosophical, theological, medical, and legal issues in a practical, working context.

3. The Precedential Core

In 1976 the New Jersey Supreme Court in the case of *In re Quinlan*,⁷⁷⁷ implicitly determined that in the case of a terminal afflic-

privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or morals." *Id.* at 623; see also G. GRISEZ & J. BOYCE, JR., *supra* note 14, at 98 *passim*; Delgado, *Euthanasia Reconsidered — The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZ. L. REV. 474 (1975).

⁷⁷² See, e.g., *In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). See generally Ford, *Refusal of Blood Transfusions by Jehovah Witnesses*, 10 CATH. LAW. 212 (1964); Paris, *Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?*, 10 U.S.F. L. REV. 25 (1975).

⁷⁷³ See, e.g., *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

⁷⁷⁴ Friendly, *The Courts and Social Policy: Substance and Procedure*, 33 U. MIAMI L. REV. 21 (1978).

⁷⁷⁵ See *Truman v. Thomas*, 27 Cal. 3d 285, 611 P.2d 902, 165 Cal. Rptr. 308 (1980); *Crisher v. Spak*, 122 Misc. 2d 355, 471 N.Y.S.2d 741 (Sup. Ct. 1983).

⁷⁷⁶ See *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

⁷⁷⁷ 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* *Garger v. New Jersey*, 429 U.S. 922 (1976).

tion that offers no hope of reversal, one effectively has a *right* to die.⁷⁷⁸ Consequently, *Quinlan* became the first major judicial decision approving the discontinuation of life-supporting treatments.

Even though prior decisions had refused to allow a patient's consent as a defense to criminal liability, the court found other reasons to conclude that criminal liability would not be imposed under the facts of this case.⁷⁷⁹ Specifically, the effects of disconnecting Ms. Quinlan's respirator would be a *natural* result of her affliction and not the result of criminal agency.⁷⁸⁰ Furthermore, because the court based its decision on the free exercise of Ms. Quinlan's right of privacy, the criminal law could not be utilized to punish the exercise of this constitutional right.⁷⁸¹ This constitutional recognition, growing out of the holding in *Griswold v. Connecticut*,⁷⁸² served to protect the individuals, *i.e.*, the physicians, who effectuated the exercise of the privacy right.⁷⁸³

Miss Quinlan's father, supported unanimously by the family, was given the authority to withdraw the respirator which all medical experts agreed was keeping her alive.⁷⁸⁴ Tragically, she remained alive for ten years after she was removed from the respirator.⁷⁸⁵ Even though this withdrawal of artificial respiration occurred, it is interesting to note that her father never sought judicial permission to withdraw nutrition and hydration from her — acts that could be recognized as extraordinary given the prognosis of her recovery.⁷⁸⁶

In 1977, one year after *Quinlan*, the Massachusetts Supreme Judicial Court decided *Superintendent of Belchertown State School v. Saikewicz*.⁷⁸⁷ Joseph Saikewicz was a retarded, incompetent sixty-seven-year-old patient at a state mental health facility who suffered from an incurable form of leukemia.⁷⁸⁸ The court held that before Saikewicz could decline an extraordinary course of treatment (*e.g.*, chemotherapy) that would temporarily sustain his life but bring complicated and seri-

⁷⁷⁸ See *id.*; see also Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267 (1977).

⁷⁷⁹ See *Quinlan*, 70 N.J. at 51-52, 355 A.2d at 669-70.

⁷⁸⁰ *Id.*

⁷⁸¹ *Id.*

⁷⁸² 381 U.S. 479 (1965).

⁷⁸³ See *Quinlan*, 70 N.J. at 51-52, 355 A.2d at 669-70.

⁷⁸⁴ See *Quinlan Dies — Decade in Coma*, USA Today, June 12, 1985, at 1A, col. 2.

⁷⁸⁵ *Id.*

⁷⁸⁶ See *id.*

⁷⁸⁷ 373 Mass. 728, 370 N.E.2d 417 (1977).

⁷⁸⁸ 373 Mass. at 729, 370 N.E.2d at 418.

ous painful side effects,⁷⁸⁹ a probate court could first determine whether he had properly exercised his right to refuse treatment as guaranteed by the fourteenth amendment's right of privacy.⁷⁹⁰

Although criticized by the medical profession as an offensive and unwarranted intrusion into the practice of medicine,⁷⁹¹ the court reasoned that it had no other recourse than to intervene.⁷⁹² Utilizing the doctrine of substituted judgment, the court considered whether Mr. Saikewicz would have wished the invasive medical treatment,⁷⁹³ and whether his best interests would in fact be served by such a course of action.⁷⁹⁴ The court struggled with its responsibility to preserve life yet maintain the personal autonomy of all citizens so that their best interests would be protected in all circumstances.⁷⁹⁵ It also inherently utilized a cost-benefit analysis in applying the primary doctrine of substituted judgment,⁷⁹⁶ evaluating the potential for short-term benefits from the chemotherapy versus the long-term pain, discomfort, and disorientation that would follow.⁷⁹⁷ Ultimately, the court decided that the value of the *potential* remission was not adjudged significant enough to merit chemotherapy treatment.⁷⁹⁸

Within a year, a new Massachusetts case was litigated that departed from *Saikewicz*.⁷⁹⁹ In *In re Dinnerstein*,⁸⁰⁰ the Massachusetts Court of Appeal was presented with a case of first impression — involving,

⁷⁸⁹ *Id.* at 733, 370 N.E.2d at 421.

⁷⁹⁰ *Id.* at 739, 370 N.E. 2d at 424. Recognizing the right to refuse medical treatment in appropriate circumstances "must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." *Id.* at 747, 370 N.E.2d at 427.

⁷⁹¹ See Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499 (1978).

⁷⁹² *Saikewicz*, 373 Mass. at 759, 370 N.E.2d at 444.

⁷⁹³ *Id.* at 752-53, 370 N.E.2d at 431.

⁷⁹⁴ *Id.* at 738, 370 N.E.2d at 423. The *Saikewicz* court distinguished its actions from the *Quinlan* court's in which parents determined, based on past experiences with their daughter, that she would not have wished respiratory assistance. *Id.* at 751, 370 N.E.2d at 430. The *Saikewicz* court had no such interested relative to consult regarding what Mr. Saikewicz would have wished; therefore, the court was compelled to intervene. *Id.*

⁷⁹⁵ *Id.* at 741, 370 N.E. 2d at 425.

⁷⁹⁶ *Id.* at 731-32, 370 N.E. 2d at 420-22.

⁷⁹⁷ *Id.*

⁷⁹⁸ *Id.* The two powerful principles the *Saikewicz* court advanced were that courts, not physicians, should make the ultimate decisions about life and death and that these judicial decisions should always reflect what the patient, herself, would have chosen. Stone, *Judges As Medical Decision Makers*, 12 THE HUMAN LIFE REV. 84, 91 (1986).

⁷⁹⁹ See *In re Dinnerstein*, 380 N.E.2d 134 (Mass. App. Div. 1978).

⁸⁰⁰ *Id.*

namely, the issuance of an ONTR.⁸⁰¹ The court held that an attending family physician, acting with family consent or agreement and without prior approval from a probate court, may issue an ONTR in the event of respiratory failure or cardiac arrest for a patient who is incompetent and terminally ill.⁸⁰²

Recognizing that the case presented questions directly within the competence of the medical profession, and consistent with her family's wishes, the court found no reason to apply the doctrine of substituted judgment.⁸⁰³ Shirley Dinnerstein was a sixty-seven-year-old widow, who suffered from the advanced stages of Alzheimer's disease as well as from a coronary condition.⁸⁰⁴ After suffering a stroke, her adult son and daughter together with her physician sought declaratory relief to determine whether her attending physician could lawfully enter a "no-code" order if she suffered cardiopulmonary arrest.⁸⁰⁵ *Dinnerstein*, unlike *Saikewicz*, could not be construed as a "right to treatment" case simply because there was no course of treatment that could significantly improve her degenerative condition.

Thus, the difference between *Dinnerstein* and *Saikewicz* is not as startling. The two Massachusetts courts are merely making a valid and thoughtful distinction between a patient who will in the near future die from one who is in the current process of dying. The significance of this distinction was stated and elaborated upon by the Massachusetts Supreme Judicial Court in its case of *In re Spring*.⁸⁰⁶

In *Spring*, Earle N. Spring, a seventy-seven-year-old man suffering from advanced senility and end-stage kidney disease, was being heavily sedated three times a week to make him more compliant to receiving five-hour hemodialysis treatments.⁸⁰⁷ Both his wife and his only son requested that his treatment be stopped; but his physicians refused to comply.⁸⁰⁸ Mrs. Spring and her son, his father's temporary legal guardian, then asked the probate court for an order directing that the physicians cease life-sustaining treatment.⁸⁰⁹ The probate court held an evidentiary hearing upon receiving a report from the court-appointed

⁸⁰¹ See *id.*

⁸⁰² *Id.* at 139.

⁸⁰³ *Id.*

⁸⁰⁴ *Id.*

⁸⁰⁵ *Id.*

⁸⁰⁶ 405 N.E.2d 115 (Mass. App. Div. 1980).

⁸⁰⁷ *Id.*

⁸⁰⁸ *Id.* at 117.

⁸⁰⁹ *Id.* at 118.

guardian *ad litem*.⁸¹⁰ The court subsequently ruled that all treatment decisions were to be made by Mrs. Spring and her son *and* the attending physician.⁸¹¹ The guardian *ad litem* appealed and, granting the motion, the probate court stayed its own judgment.⁸¹²

On appeal, the *Spring* court chose to draw a distinction between a patient for whom further treatment would be of no value and one for whom additional treatment would be a genuine alternative.⁸¹³ Although the court concluded that death was indeed inevitable for Mr. Spring, it acknowledged the remote possibility that he "might regain competence, experience lucid intervals, or even be able to express a 'sensible opinion' as to his desire."⁸¹⁴ The probate court was then forced to modify its order.⁸¹⁵ The appellate court ordered no further use of life-prolonging treatment and went further in holding that the probate court, and it alone, not Mr. Spring's wife nor his son nor attending physician, was the proper party to determine the extent to which the substituted judgment standard would be applied.⁸¹⁶ Ultimately, the court found that the standard of substituted judgment had been properly applied and met.⁸¹⁷

In New York, the courts were less understanding and more conservative than in Massachusetts in their decisions to forego treatment. In *In re Eichner*⁸¹⁸ and its companion case, *In re Storar*,⁸¹⁹ the courts held that it was unnecessary to determine whether the right to refuse treatment was an inherent element in the fourteenth amendment's right to privacy because common-law principles supported its recognition.⁸²⁰ The doctrine of substituted judgment was not a point of contention because clear and convincing evidence would always be required to prove that an individual was competent when she decided to initiate or discontinue treatment.⁸²¹ Furthermore, the *Storar* court refused to follow *Saikewicz*'s application of the doctrine of substituted judgment and held that life-prolonging treatment of a terminally ill, incompetent cancer

⁸¹⁰ *Id.*

⁸¹¹ *Id.*

⁸¹² *Id.*

⁸¹³ *Id.* at 123.

⁸¹⁴ *Id.*

⁸¹⁵ *Id.*

⁸¹⁶ *Id.* at 117, 122.

⁸¹⁷ *Id.* at 122.

⁸¹⁸ 73 A.D.2d 431, 426 N.Y.2d 517 (App. Div. 1980), *rev'd*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

⁸¹⁹ 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

⁸²⁰ *Id.* at 376-77, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73 (consolidated with *Eichner*).

⁸²¹ *Id.* at 378-79, 420 N.E.2d at 71-72, 438 N.Y.S.2d at 273-74.

victim could not be withdrawn.⁸²²

In *Eichner*, Brother Fox, an eighty-three-year-old member of the Roman Catholic Society of Mary, went into cardiac arrest during a routine hernia operation.⁸²³ He lost oxygen for only a few moments and, while in a state of coma, he was placed on a respirator.⁸²⁴ Brother Fox suffered substantial brain damage and had no reasonable chance of making any type of recovery.⁸²⁵ When a close friend, Father Philip Eichner, requested that the respirator be removed, the hospital refused, and this present action was initiated.⁸²⁶ The Appellate Division of the New York Supreme Court held that the right to refuse treatment was an inherent, protected guarantee found within the common law.⁸²⁷ Additionally, under the fourteenth amendment's right to privacy, this right could be exercised by applying the doctrine of substituted judgment.⁸²⁸ Heavy reliance was placed upon the *Saikewicz* and *Spring* Massachusetts precedents.⁸²⁹ The New York Court of Appeal rejected the majority of the appellate court's analysis and skirted the major problem by finding that, when Brother Fox was competent, he had expressed the view that he never wished to be maintained on artificial life supports.⁸³⁰

In the companion case of *In re Storar*,⁸³¹ a fifty-two-year-old retarded man, John Storar, was afflicted with terminal bladder cancer

⁸²² *Id.* at 380, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

⁸²³ *Eichner*, 52 N.Y.2d at 371, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.

⁸²⁴ *Id.*

⁸²⁵ *Id.*

⁸²⁶ *Id.*

⁸²⁷ *Id.* at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

⁸²⁸ *Id.*

⁸²⁹ See *In re Eichner*, 73 A.D. 431, 426 N.Y.2d 517 (App. Div. 1980), *rev'd*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

⁸³⁰ *Eichner* 52 N.Y.2d at 378-80, N.E.2d at 71-72, 438 N.Y.S.2d at 273-74. On October, 14, 1988, the New York Court of Appeals ruled that life sustaining medical treatment cannot be withheld from an incompetent patient unless, while competent, the patient made a clear and resolute decision to reject such treatment. *In re O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). Chief Judge Wachtler stated:

[The patient's] statements with respect to declining artificial means of life support were generally prompted by her experience with persons suffering terminal illnesses, particularly cancer. However, [she] does not have a terminal illness, except in the sense that she is aged and infirm. Neither is she in a coma nor vegetative state. . . . She is in a stable condition and if properly nourished will remain in that condition unless some other medical problem arises.

Id. at 533, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.

⁸³¹ 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

causing him regularly to lose blood.⁸³² In order to replace that which he lost, he was subjected to blood transfusions.⁸³³ His mother and guardian sought to discontinue the transfusions — even though Storar had more energy after them and was able to resume his “normal” routine.⁸³⁴ Because Storar’s infant mentality prevented the court from ascertaining his wishes about a continuation of potentially life-prolonging treatment, the court held that the artifice of substituted judgment could not be employed by an infant’s parent or guardian to deprive a child of life-saving treatment — especially since the transfusions were analogous to food.⁸³⁵ Tragically, while being so quick to criticize and reject the application of the doctrine of substituted judgment, the court chose to disregard the opportunity to develop a new framework for principled decision making. Instead, they simply called upon a mandatory procedure to be forthcoming from the legislature.⁸³⁶

In the combined 1983 decision of *Barber v. Superior Court* and *Nejdl v. Superior Court*,⁸³⁷ the California Court of Appeal for the Second District for the first time equated the discontinuation of an intravenous feeding with the removal of a respirator or any other medical intervention.⁸³⁸ The court declared that each procedure was a medical treatment and could only be used if it benefitted the patient.⁸³⁹ Thus, if the intervention merely sustains biological functions, it should not be regarded as a treatment — but, rather as a useless gesture and one the physician is not obligated to follow.⁸⁴⁰ Especially significant is the court’s shift in its analysis from the more traditional emphasis of “ordinary v. extraordinary” means of treatment to a “proportionate-disproportionate” benefits standard.⁸⁴¹ In essence, the court shifts the focus from medical treatment involved to the *condition* of the patient that would result if the treatment were either started or retained.⁸⁴²

Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient’s condition. On

⁸³² *Id.* at 373-74, 420 N.E.2d at 68-69, 438 N.Y.S.2d at 270-71.

⁸³³ *Id.*

⁸³⁴ *Id.* at 374-75, 420 N.E.2d at 69-70, 438 N.Y.S. 2d at 271-72.

⁸³⁵ *Id.* at 380-81, 420 N.E.2d at 73, 438 N.Y.S. 2d at 275.

⁸³⁶ *Id.* at 382-83, 420 N.E.2d at 73-74, 438 N.Y.S.2d at 276.

⁸³⁷ 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

⁸³⁸ *Id.* at 1016, 195 Cal. Rptr. at 490.

⁸³⁹ *Id.* at 1019, 195 Cal. Rptr. at 491.

⁸⁴⁰ *Id.*

⁸⁴¹ *Id.* at 1018-19, 195 Cal. Rptr. at 491.

⁸⁴² *Id.* at 1019, 195 Cal. Rptr. at 491-92.

the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.⁸⁴³

Shortly after surgery for closure of an ileostomy, Clarence Herbert suffered a cardiopulmonary arrest, went into a coma and was placed on a respirator.⁸⁴⁴ After five days, the physicians determined his condition to be irreversible and so advised his wife and family.⁸⁴⁵ After obtaining permission from the wife, use of the respirator was discontinued.⁸⁴⁶ Nevertheless, Mr. Herbert continued to live in a state of coma.⁸⁴⁷ Thereupon, the doctors received written permission from Mrs. Herbert to terminate the administration of nutrition and hydration.⁸⁴⁸ Six days later, he died — but during those days he “received nursing care which preserved his dignity and provided a clean and hygienic environment.”⁸⁴⁹

The issue confronting the court of appeal was whether the two attending physicians, Dr. Barber and Dr. Nejd, should be held guilty of murder and conspiracy to commit murder.⁸⁵⁰ The court, in reaching a conclusion that no charge of this nature would be sustained, chose to view the conduct of the physicians “as that of omission rather than affirmative action.”⁸⁵¹ The court stated:

There is no criminal liability for failure to act unless there is a legal duty to act. . . .⁸⁵²

. . . .
A physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.⁸⁵³

. . . .
No precise guidelines as to when or how these decisions should be made can be provided by this court since this determination is essentially a medical one to be made at a time and on the basis of facts which will be

⁸⁴³ *Id.* at 1019, 195 Cal. Rptr. at 491.

⁸⁴⁴ *Id.* at 1018, 195 Cal. Rptr. at 490.

⁸⁴⁵ *Id.*

⁸⁴⁶ *Id.*

⁸⁴⁷ *Id.* at 1010, 195 Cal. Rptr. at 486.

⁸⁴⁸ *Id.*

⁸⁴⁹ *Id.* at 1011, 195 Cal. Rptr. at 486.

⁸⁵⁰ *Id.*

⁸⁵¹ *Id.* at 1017, 195 Cal. Rptr. at 490.

⁸⁵² *Id.*

⁸⁵³ *Id.* at 1017-18, 195 Cal. Rptr. at 491.

unique to each case.⁸⁵⁴

The *Barber-Nejdl* court stressed its position that judicial intervention was not required in cases of this nature, unless ordered by the legislature.⁸⁵⁵ Indeed, a requirement of judicial intervention in all similar cases should be viewed as not only unnecessary, but unwise.⁸⁵⁶ The court agreed that Mrs. Herbert was the proper surrogate decision maker for her husband and that his previous expressions of not wishing to "become another Karen Ann Quinlan" had been taken into full account in reaching the ultimate decision.⁸⁵⁷ Furthermore, the court noted that in those cases when it was not possible to determine the choice the patient would have made, the surrogate should be guided in her decision making by the "patient's best interests."⁸⁵⁸

In April 1984 seventy-year-old William Bartling was admitted to the Glendale Adventist Medical Center in California for treatment of depression.⁸⁵⁹ Suffering from emphysema, arteriosclerosis, and an abdominal aneurysm, an examination revealed him to have a malignant lung tumor.⁸⁶⁰ During efforts to obtain a biopsy of the tumor, however, the lung collapsed and failed to reinflate.⁸⁶¹ A tracheotomy was performed

⁸⁵⁴ *Id.* at 1018, 195 Cal. Rptr. at 491.

⁸⁵⁵ *Id.*

⁸⁵⁶ *Id.* at 1022, 195 Cal. Rptr. at 493.

⁸⁵⁷ *Id.*

⁸⁵⁸ *Id.* at 1021, 195 Cal. Rptr. at 493. The factors to consider would include relief of suffering, preservation or restoration of functioning capacities, quality and extent of sustainable "life," and the ultimate decision's impact on those closest to the patient. *Id.*; see also Lo, *The Death of Clarence Herbert: Withdrawing Care is Not Murder*, 101 ANNALS INTERNAL MED. 48 (1984); Lynn & Childress, *supra* note 664, at 17.

The Massachusetts Court of Appeal cited *Barber* approvingly in *In re Mary Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984), to support its ruling that a 92 year old incompetent patient who pulled out her gastrostomy tube did not need to undergo forced surgical intervention to have the tube reinserted. *Id.* at 201, 464 N.E.2d at 959. The court decided the case fully knowing that the patient's intravenous feeding was used only as a short-term technique to maintain hydration rather than as a balanced diet. *Id.* at 203, 464 N.E.2d at 961. Acknowledging that the substituted judgment test as used was valid and proper, *id.* at 207-10, 464 N.E.2d at 963-66, the court concluded that medical nutrition and fluids were to be administered similarly to any other medical intervention: to accord with a balance of benefits and burdens to the patient. *Id.* at 207, 464 N.E.2d at 964. The court further stated that such actions in certain circumstances do not violate either the law or medical ethics. *Id.*

⁸⁵⁹ *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 190, 209 Cal. Rptr. 220, 221 (1984).

⁸⁶⁰ *Id.* at 190, 209 Cal. Rptr. at 221.

⁸⁶¹ *Id.*

and Mr. Bartling was placed on a respirator.⁸⁶² Requests made by Mr. Bartling and his wife to the physicians for the removal of the respirator were to no avail.⁸⁶³ Thus, in June 1984, Mr. Bartling sought to enjoin both the hospital and the physicians from administering further treatment.⁸⁶⁴ Bartling also sought damages for nonconsensual treatment in violation of his state and constitutional rights, for breach of the fiduciary duty owed to him by the hospital and his treating physicians, for intentional infliction of emotional distress, and for conspiracy.⁸⁶⁵

Mr. Bartling had executed a signed and properly witnessed nonstatutory "living will" stating his direction that should he be placed in a situation of "extreme physical or mental disability" in which there was no "reasonable expectation" of recovery, he wished to be allowed to die.⁸⁶⁶ Additionally, he had executed a declaration under the state Natural Death Act underscoring his wish to die with dignity rather than continue in the "intolerable" manner in which he was living.⁸⁶⁷ He also executed a durable power of attorney for health care with his wife in which he directed her to honor his desire to end his "humiliating indignity" by refusing ventilator support.⁸⁶⁸ Both Mr. Bartling and his wife — together with their daughter — signed a release which relieved the hospital and physicians from civil liability.⁸⁶⁹ In spite of all of these measures, the physicians found Mr. Bartling's condition not terminal.⁸⁷⁰ He could potentially live for a year if weaned from the respirator.⁸⁷¹ However, real doubts existed about the feasibility of this action.⁸⁷² Furthermore, although not questioning his legal competency, the physicians questioned Bartling's ability to make a meaningful decision.⁸⁷³ They also expressed concern about the ethics of disconnecting life support and the potential civil and criminal liability that might follow their actions.⁸⁷⁴

The court held that the right to disconnect a life-support mechanism

⁸⁶² *Id.*

⁸⁶³ *Id.*

⁸⁶⁴ *Id.*

⁸⁶⁵ *Id.*

⁸⁶⁶ *Id.*, 209 Cal. Rptr. at 222.

⁸⁶⁷ *Id.* at 191, 209 Cal. Rptr. at 222.

⁸⁶⁸ *Id.*

⁸⁶⁹ *Id.*

⁸⁷⁰ *Id.*

⁸⁷¹ *Id.* at 192, 209 Cal. Rptr. at 223.

⁸⁷² *Id.*

⁸⁷³ *Id.*

⁸⁷⁴ *Id.*, 209 Cal. Rptr. at 222.

was not limited to only comatose or terminally ill patients.⁸⁷⁵ Grounded in a constitutional right of privacy as it emerges from the fifth and ninth amendments, this right of patient self-determination should be regarded as "paramount to the interests of the patient's hospital and doctors."⁸⁷⁶

Disregarding the assertion that the state had a positive interest in protecting against suicide, the court held that the state's interest was in protecting only against "irrational self-destruction."⁸⁷⁷ The court noted that a patient could make a "competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope or cure of preservation of life. There is no connection between the conduct here in issue and any State concerns to prevent suicide."⁸⁷⁸ Consistent with Mr. Bartling's request, the court held that no civil or criminal liability would attach to the act of disconnecting the life-sustaining equipment; nor would advance judicial approval or intervention be required.⁸⁷⁹ The fact that Mr. Bartling executed a declaration which attested to his wish to die with dignity proved that he was aware that he would die if disconnected from the ventilator.⁸⁸⁰ Although finding that the California Natural Death Act applied only to a narrow number of terminally ill individuals and that a directive under it was not the exclusive method of refusing treatment, the court chose not to set forth a defined structure for competent patients to follow.⁸⁸¹

In 1979 Claire Conroy was eighty-four years old and residing in a nursing home.⁸⁸² She was ambulatory, and although often confused, she

⁸⁷⁵ *Id.* at 194-95, 209 Cal. Rptr. at 224-25.

⁸⁷⁶ *Id.* at 195, 209 Cal. Rptr. at 225.

⁸⁷⁷ *Id.* at 196, 209 Cal. Rptr. at 226.

⁸⁷⁸ *Id.* (citing *Saikewicz* approvingly).

⁸⁷⁹ *Id.* at 197, 209 Cal. Rptr. at 226.

⁸⁸⁰ *Id.*

⁸⁸¹ *Id.* at 194, 209 Cal. Rptr. at 224.

In *In re Torres*, 357 N.W.2d 332 (Minn. 1984), the Minnesota Supreme Court held that allowing the removal in this particular instance of a respirator required a court order. *Id.* However, the court observed the almost weekly procedure in Minnesota in which, after the physician consulted with the terminally ill patient's family and the hospital ethics committee's approved the action, terminating life support systems was undertaken. *Id.* In situations following this recognized procedure, the court would not interfere. *Id.* While this recognition was important, the court is primarily cited for recognizing that the substituted judgment test, with a conclusion to withdraw life support systems, is totally consistent with the patient's own best interests in this type of case. *Id.*; see also *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (Conn. Super. Ct. 1984).

⁸⁸² *In re Conroy*, 98 N.J. 321, 336, 486 A.2d 1209, 1216 (1985).

was able to converse.⁸⁸³ She was afflicted with arteriosclerotic heart disease, hypertension, diabetes, a gangrenous leg, and organic brain syndrome.⁸⁸⁴ She also employed a urinary catheter because she had no bowel control.⁸⁸⁵ Between 1979 and 1983, these conditions became exacerbated, especially the severe organic brain syndrome.⁸⁸⁶ A nasogastric tube was subsequently inserted which supplied her with nutrients and fluids.⁸⁸⁷ Her life expectancy with the tubal feeding was set at no more than a year; without it she was expected to die of dehydration within approximately a week's time.⁸⁸⁸

In 1983 Ms. Conroy's nephew sought judicial authorization for the removal of the nasogastric tube so that she might die.⁸⁸⁹ The trial court held that when intelligence had been permanently reduced while the patient suffered from a corresponding array of medical difficulties, life becomes impossible, and tubal nourishment could be withdrawn even though Ms. Conroy's ensuing starvation might be painful.⁸⁹⁰

Although not discussing the contention of Ms. Conroy's nephew — that if she had been competent she would have wished to be taken from her artificial (tubal) nourishment⁸⁹¹ — the intermediate appellate court refused to sustain the order of the lower court.⁸⁹² The court reasoned that Ms. Conroy appeared to be suffering no pain, and that she well might endure it if the tubal feeding were to stop.⁸⁹³ Furthermore, she was neither in a terminal condition nor permanently comatose or in a chronic vegetative state.⁸⁹⁴ Thus, since death was not imminent,⁸⁹⁵ routine life supports could *not* be withdrawn because the state interest in preserving life supports such as nutrition simply outweighed Ms. Conroy's privacy interest.⁸⁹⁶ The court also noted that before it would judicially recognize a patient's right to terminate life-sustaining treatment, the patient would need to show that no medical benefit would

⁸⁸³ *Id.*

⁸⁸⁴ *Id.*

⁸⁸⁵ *Id.* at 338-39, 486 A.2d at 1217.

⁸⁸⁶ *Id.*

⁸⁸⁷ 98 N.J. at 336, 486 A.2d at 1216.

⁸⁸⁸ *Id.* at 338, 486 A.2d at 1217-18.

⁸⁸⁹ *Id.* at 340, 486 A.2d at 1220.

⁸⁹⁰ *In re Conroy*, 188 N.J. Super. 523, 529-30, 457 A.2d 1232, 1236 (Ch. 1983).

⁸⁹¹ *In re Conroy*, 190 N.J. Super. 453, 457 n.4, 464 A.2d 303, 306 n.4 (App. Div. 1983).

⁸⁹² *Id.* at 457-58, 464 A.2d at 306-07.

⁸⁹³ *Id.* at 475, 464 A.2d at 315.

⁸⁹⁴ *Id.*

⁸⁹⁵ *Id.* at 469-70, 464 A.2d at 312.

⁸⁹⁶ *See id.* at 469, 464 A.2d at 311-12.

result from the continuation of treatment.⁸⁹⁷ No conclusive evidence on this point was shown in Ms. Conroy's care.⁸⁹⁸

The New Jersey Supreme Court reversed the Appellate Division and held that a competent adult has a general right to refuse life-sustaining medical treatment and does not lose that right because of subsequent incompetency.⁸⁹⁹ Also, under certain defined sets of circumstance, a surrogate decision maker may — acting on behalf of the incompetent — withdraw life-sustaining treatment.⁹⁰⁰

The court defined rather complex procedures that must be followed before a decision to terminate treatment (such as artificial feeding) could be withdrawn from a dying patient.⁹⁰¹ For elderly incompetent nursing home residents who "will probably die within approximately one year even with treatment,"⁹⁰² treatment could be withheld if three conditions were met: (1) it was clear that the particular patient would have refused treatment under the present circumstances (the subjective test);⁹⁰³ (2) there is some indication of the patient's wishes — even though she has not "unequivocally expressed" her desires before becoming incompetent — and the course of treatment "would only prolong suffering" (the limited-objective test);⁹⁰⁴ and (3) when there is no evidence regarding the patient's wishes but the burden of the treatment "clearly and markedly outweighs the benefits the patient derives from life" (the pure objective test).⁹⁰⁵

Under procedures set forth by the court, in the case of an incompetent patient, a judicial determination must be made that the patient is incompetent to make the decision regarding the withholding or withdrawing of life-sustaining medical treatment.⁹⁰⁶ If no guardian has been appointed, the court will do so after this determination.⁹⁰⁷ Even if previously adjudicated as incompetent, the court must determine whether the patient can make the *present* decision concerning medical treatment.⁹⁰⁸ If a guardian has already been appointed for the patient, the

⁸⁹⁷ See *id.* at 475, 464 A.2d at 315.

⁸⁹⁸ See *id.* at 466, 464 A.2d at 310.

⁸⁹⁹ *In re Conroy*, 98 N.J. 321, 388, 486 A.2d 1209, 1244-45 (1985).

⁹⁰⁰ See *id.*

⁹⁰¹ *Id.* at 360, 486 A.2d at 1229.

⁹⁰² *Id.*

⁹⁰³ *Id.* at 361, 486 A.2d at 1229.

⁹⁰⁴ *Id.* at 365, 486 A.2d at 1232.

⁹⁰⁵ *Id.* at 366-67, 486 A.2d at 1232.

⁹⁰⁶ *Id.* at 364-65, 486 A.2d at 1231.

⁹⁰⁷ *Id.*

⁹⁰⁸ *Id.*

judicial inquiry must be directed to the suitability of the guardian to make this decision.⁹⁰⁹

The guardian who believes that the actions of withholding or withdrawing would either effectuate the patient's wishes *or* meet either the second or third tests must notify the office of the State Ombudsman of the contemplated action.⁹¹⁰ Similarly, for any person who believes that the contemplated action would abuse the at-risk patient, that person may contact the Ombudsman.⁹¹¹ Upon notification of a possible abuse, the Ombudsman is required to investigate and report the matter to the Commissioner of Human Services and other concerned administrative officials.⁹¹²

The attending physician and nurses are required to furnish evidence concerning the patient's condition.⁹¹³ Two other doctors, unaffiliated with the case or the institution where the patient is being maintained, should be appointed to confirm both the condition of the patient and her prognosis.⁹¹⁴ If the two physicians present the necessary medical foundation, the guardian may then — with the concurrence of the attending physician and the Ombudsman — proceed to either withhold or withdraw life-sustaining medical treatment.⁹¹⁵ The decision maker must have a good faith belief, based on medical evidence and evidence supporting the wishes of the patient, that one of these tests is met.⁹¹⁶ In the case of the use of the limited-objective test, the patient's next of kin must also concur.⁹¹⁷ Because of the complexity of the tests and their procedural requirements, it is very difficult to imagine a situation in which treatment would be withheld or withdrawn under the *Conroy* structure.⁹¹⁸

⁹⁰⁹ *Id.* at 364-66, 486 A.2d at 1230-31.

⁹¹⁰ *Id.* at 383, 486 A.2d at 1241-42.

⁹¹¹ *Id.*

⁹¹² *Id.*

⁹¹³ *Id.* at 384, 486 A.2d at 1242.

⁹¹⁴ *Id.*

⁹¹⁵ *Id.*

⁹¹⁶ *Id.*

⁹¹⁷ *Id.*

⁹¹⁸ For example, if an incompetent's guardian believed under one of the objective tests that actions terminating life-sustaining treatments were in the patient's best interest and proceeded to follow the court's mandatory set procedure, treatment could be continued as a consequence of but one dissent from a family member. In addition, if the same judicially designed procedure were followed and the patient's entire family concurred that such actions were in the patient's best interests, and assuming further that all other conditions were satisfied, one of the two physicians necessarily appointed by the State Ombudsman for the Institutionalized Elderly — if hesitant to agree regarding

On February 26, 1986, a New Jersey State Superior Court Judge ruled that Nancy Ellen Jobes, who had been unconscious since April 1980, had a right to remove a feeding jejunostomy tube which was surgically implanted in her small intestine.⁹¹⁹ Mrs. Jobes' husband had maintained the action for removal of her feeding system.⁹²⁰ The Lincoln Park Nursing Home, where Mrs. Jobes was a patient, opposed the action and sought its own appointment as a "life advocate" who would "fight for the life" of Mrs. Jobes.⁹²¹

In disallowing the claim of the nursing home for an appointment of a guardian *ad litem*, the court observed that

it is not the function of the guardian *ad litem* in these life-support cases to argue for continuation of the incompetent ward's life in each and every case. Such a view misconceives the time-honored obligation of the guardian *ad litem* to act in the *best interests* of the ward.⁹²²

The court explained that a policy which mandated extraordinary life-supporting measures in all cases involving terminal care would violate an individual's constitutional and common-law right of privacy.⁹²³ The court also concluded that both the competent and the incompetent possess the *same* right of self-determination in matters of this nature.⁹²⁴

In a 6-1 decision, delivered June 24, 1987, the New Jersey Supreme Court found that the trial court had properly determined that there was "clear and convincing" evidence that Mrs. Jobes was in a persistent vegetative state.⁹²⁵ Finding further that Nancy Jobes' situation was directly analogous to Karen Quinlan's, the court held that nutrition and hydration were medical treatment issues which could be withheld or withdrawn on behalf of the afflicted patient.⁹²⁶ Interestingly, on this point, the Supreme Court reversed the trial court's finding that clear and convincing evidence had been adduced, after finding that Mrs. Jobes had not made sufficiently specific statements, but instead had

the patient's condition — could cause treatment to be continued. In sum, the *Conroy* procedures cause too many check-points that result in road-blocks. See Comment, *Natural Death: An Alternative in New Jersey*, 73 GEO. L.J. 1331, 1351 (1985); see also Annas, *supra* note 665, at 24.

⁹¹⁹ *In re Jobes*, 210 N.J. Super. 543, 545, 510 A.2d 133, 134-35 (1986), *aff'd*, 108 N.J. 394, 529 A.2d 434 (1987).

⁹²⁰ 210 N.J. Super. at 545, 510 A.2d at 134-35.

⁹²¹ *Id.* at 543, 510 A.2d at 134.

⁹²² *Id.*, 510 A.2d at 135 (emphasis added).

⁹²³ *Id.* at 547, 510 A.2d at 136.

⁹²⁴ *Id.*

⁹²⁵ *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

⁹²⁶ *Id.* at 426-28, 529 A.2d at 439-41.

made statements that were "remote, general, spontaneous and made in casual circumstances."⁹²⁷

Even with this ruling, Justice Garibaldi, speaking for the majority court, acknowledged that tubal feeding could be ended if members of the Jobs family exercise their best, substituted judgment after considering the wishes and motives that would control Mrs. Jobs' medical decisions.⁹²⁸ If close, caring members of the patient's family are willing to make critical care decisions, the court would neither appoint a guardian, nor would it review the family's decision.⁹²⁹ If an incompetent patient has no close family members, and has failed to establish clear and convincing evidence of her wish to have a distant relative or friend make a surrogate medical decision, a guardian must be appointed.⁹³⁰

Even though Mrs. Jobs was in a nursing home, the court determined that the decision making process for surrogates "should be substantially the same regardless of where the patient is located."⁹³¹ The court established a set of guidelines that would remove criminal or civil liability for the implementation of any good faith surrogate decision to decline medical treatment.⁹³² Simple and straightforward, the guidelines recognize that certain safeguards which exist in hospitals are not usually found in nursing homes.⁹³³ Thus, for the nursing home patient under sixty years of age who is "non-elderly" and "non-hospitalized" but in a persistent vegetative state, the surrogate decision maker must secure statements from at least two independent physicians before declining life-sustaining medical treatment.⁹³⁴ The statements must allege that the patient is in a persistent vegetative state without any reasonable possibility of recovery.⁹³⁵

The New Jersey Supreme Court reversed the lower court's decision which allowed the Lincoln Park Nursing Home to refuse to withdraw Mrs. Jobs' feeding tube.⁹³⁶ The court reasoned that since the Jobs family had no reason to believe it was foregoing the right to select among various medical alternatives when Mrs. Jobs was placed in

⁹²⁷ *Id.* at 428, 529 A.2d at 441.

⁹²⁸ *Id.* at 430-32, 529 A.2d at 444-47.

⁹²⁹ *Id.* at 431, 529 A.2d at 446.

⁹³⁰ *Id.* at 432, 529 A.2d at 447.

⁹³¹ *Id.* at 433, 529 A.2d at 448.

⁹³² *Id.* at 433-34, 529 A.2d at 448-49.

⁹³³ *Id.* at 433, 529 A.2d at 448.

⁹³⁴ *Id.*

⁹³⁵ *Id.*

⁹³⁶ *Id.* at 447, 529 A.2d at 450.

Lincoln Park and, because it would be extremely burdensome to locate another nursing home facility that would accept her, discharging her from the Lincoln Park Home would essentially frustrate Mrs. Jobes' right of self-determination.⁹³⁷

⁹³⁷ *Id.*

On June 24, 1987, two other cases involving the right to refuse medical treatment were in close proximity decided with *Jobes* by the New Jersey Supreme Court: *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987), and *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987). In *Farrell*, a woman in her early thirties suffered from amyotrophic lateral sclerosis (or Lou Gehrig's disease), was paralyzed, was on a respirator, and required around-the-clock nursing care *at home*; she was, however, able to express her wish to be removed from the respirator. 108 N.J. at 335, 529 A.2d at 404. Upon petition to the trial court by Kathleen Farrell's husband and children for authority to disconnect her respirator and for a declaratory judgment to negate civil and criminal liability for such actions, the requested relief was granted. *Id.* However, while awaiting appellate review, Mrs. Farrell died connected to her respirator. *Id.* The New Jersey Supreme Court nonetheless proceeded to decide that a competent patient has the right to refuse life-sustaining medical treatment. 108 N.J. at 349, 529 A.2d at 413. Moreover, when a competent patient living at home requests to discontinue such life-sustaining medical treatment, the first procedure that must be followed is to establish: her competency, that she has been properly informed about her prognosis, available alternative treatments, and the risks involved in withdrawing the life-sustaining treatment. *Id.*, 529 A.2d at 413-14. Thereafter, two independent physicians must examine the patient at home to confirm both the patient's competence and the fact that all necessary information has been given. *Id.* at 354, 529 A.2d at 414-15. Unless a situation presents an unusual set of circumstances (*i.e.*, conflict among physicians, family members or other health-care providers), the actions will not judicially be reviewed. *Id.*, 529 A.2d at 415. Emphasizing its respect and confidence in the family unit's approach to treating its sick members, the court stressed that decision making should be unencumbered by legal processes, but it should entail the advice of a physician. *Id.* The court stated, "Thus, we do not want to impose any restrictions or burdens on the competent patient's right to have life-sustaining treatment withdrawn if he or she is at home that would not be present if he or she were in a hospital or nursing home." *Id.* at 353, 529 A.2d at 414.

In *Peter*, Hilda M. Peter, while in her early sixties, collapsed in the home she shared with Everhard Johanning. 108 N.J. 365, 529 A.2d at 419. She was resuscitated, but was moved to a New Jersey nursing home where she remained permanently unconscious and in a persistent vegetative state sustained by a nasogastric feeding tube. *Id.* Although she had executed no living will, Ms. Peter had conveyed a power of attorney to Mr. Johanning in 1983 — a year before her collapse — authorizing him to make all health decisions on her behalf and "to be given full and complete authority to manage and direct (her) medical care." *Id.* at 371, 529 A.2d at 422. The court concluded that the evidence established clearly that — if competent — she would choose to withdraw her feeding tube. *Id.* at 378, 529 A.2d at 426-27. Since none of the various traditional state interests were found to be sufficiently strong to overcome Ms. Peter's right to refuse medical treatment, and since no prognosis committee existed at the nursing home, the State Ombudsman for the Institutionalized Elderly needed to obtain two independent medical opinions confirming that no reasonable possibility existed for the

This ruling extends both *Quinlan* and *Conroy*; while removal of a respirator may or may not cause death within the foreseeable future, as with Ms. Quinlan's case, the withdrawal of artificial feeding and its recognition as treatment means that in most cases death will occur within one or two weeks.⁹³⁸ In *Conroy* although the court recognized artificial feeding as a medical procedure which could be withdrawn from a dying patient, for incompetent nursing home residents, a complicated procedure was set forth making the whole matter exceedingly cumbersome.⁹³⁹ In *Jobes* the simple recognition of the right of self-determination and its coordinate right of withdrawal of *treatment* made the process neat and unencumbered.⁹⁴⁰

patient's recovery to a cognitive sapient state before life-sustaining treatment was withdrawn. *Id.* at 382, 529 A.2d at 429. The court distinguished the instant case in which Ms. Peters was existing in a persistent vegetative state from the *Conroy* case in which Ms. Conroy's condition was similar to Karen Quinlan's. *Id.* at 377, 529 A.2d at 424. Thus, the proper inquiry was whether a *reasonable* possibility existed that the patient would return to a cognitive and sapient life. *Id.* With Ms. Peter, no such possibility existed. *Id.*

⁹³⁸ See Sullivan, *Jersey Judge Permits Denial of Food to Patient in Coma*, N.Y. Times, Apr. 24, 1986, at 17, col. 5; see also John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (court refused to become involved in determining whether withdrawal of respirator should be allowed — deferring instead to either the family or appointed guardian to discharge incompetent's right to refuse extraordinary medical treatment).

⁹³⁹ *Conroy*, 98 N.J. at 368, 486 A.2d at 1237.

⁹⁴⁰ See *supra* notes 931-35 and accompanying text. In *Jobes*, convincing evidence existed that Mrs. Jobes had previously expressed on several occasions her wish never to be sustained on artificial life supports if she became helpless. *Jobes*, 210 N.J. Super. at 543, 510 A.2d at 133.

In *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987), the court held that a right to refuse treatment to incompetents and to those who previously had not articulated their desire to refuse could be considered in one's best interests and furthered in certain circumstances of withholding or withdrawing treatment. *Id.* The court also determined that using "extraordinary medical treatment" could be regarded as including artificially supplied nutrition and hydration. *Id.* Although recognizing state natural death acts as providing a convenient form to avoid complications in exercising the right to refuse treatment, the court acknowledged that these acts were not the sole or exclusive procedure by which the right could be exercised. *Id.* at 216, 741 P.2d at 680.

On July 23, 1987, acting partly to affirm and partly to reverse the appellate decision, the Arizona Supreme Court held that Ms. Rasmussen had the right to refuse medical treatment and that this right was protected not only by the common law, but also by state and federal constitutions. *Id.* at 217-18, 741 P.2d at 681-83. Agreeing with the appellate court, the Arizona Supreme Court held that the ethical integrity of the medical profession would not be compromised by either "Do Not Resuscitate" or "Do Not Hospitalize" Orders. *Id.* at 219-21, 741 P.2d at 684-85. The Court added that no material distinction existed between irreversible coma and Ms. Rasmussen's irreversible

On November 1, 1983, Elizabeth Bouvia, a competent, college-educated, nonterminally ill county hospital patient asked a court of law for permission to starve herself to death because her disabilities made her unable to take her own life.⁹⁴¹ Unfortunately, she never realized that her quest for enlightened self-determination would not be recognized until April 16, 1986.⁹⁴² She initially sought a prohibitory injunction against the Riverside General Hospital's administering any health care without her consent.⁹⁴³ She predicated her claim on the right of personal autonomy or self-determination to decide when and how her life should end, and that there was a societal obligation to render her assistance in executing that right.⁹⁴⁴ The defendants alleged that she had no such statutory, constitutional, ethical, or moral right to undertake this action and, if she did have the right, it could be overcome by compelling state interests.⁹⁴⁵

Since birth, Ms. Bouvia has suffered from severe cerebral palsy, and, as a quadriplegic, she has virtually no motor function in her limbs.⁹⁴⁶ She does have slight muscular control which allows her to operate an electric wheelchair.⁹⁴⁷ Voluntary control of her face, mouth, and throat allows her to eat a normal diet fed to her and allows her to converse.⁹⁴⁸ At the time she filed her action, her cerebral palsy was not of a progressive nature.⁹⁴⁹ The trial court found that Ms. Bouvia had the right, under the unwritten right of privacy and self-determination found in the first, fourth, fifth and fourteenth amendments, to terminate her ex-

chronic vegetative state. *Id.* at 221, 741 P.2d at 685. Finally, in deciding a ward, the court held that the guardian should be guided by either the substituted judgment standard or by the best interests standard; furthermore, when there is no evidence at all regarding the choice the patient would have made — as with Ms. Rasmussen — the surrogate decision maker should utilize the best interests standard. *Id.* The court held the quality of life — as an objective standard of evaluation — to refer to the patient's value in continued life and not the value others find in the patient's continued life. *Id.* Relief from suffering was also considered an objective standard which the surrogate decision maker should consider. *Id.* at 222-23, 741 P.2d at 688-89.

⁹⁴¹ Reporter's Transcript at 1238-50, *Bouvia v. County of Riverside*, No. 159780 (Dec. 16, 1983).

⁹⁴² See *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

⁹⁴³ The trial court decision is reproduced in 1 *ISSUES IN LAW & MEDICINE* 486 (1986). Subsequent references are from this journal.

⁹⁴⁴ *Id.*

⁹⁴⁵ *Id.*

⁹⁴⁶ *Id.*

⁹⁴⁷ *Id.*

⁹⁴⁸ *Id.*

⁹⁴⁹ *Id.* at 487.

istence.⁹⁵⁰ However, Ms. Bouvia could not assert this right while she was in a nonterminal condition with the assistance of society.⁹⁵¹ Therefore, her petition for injunctive relief was denied.⁹⁵² The court, without any supporting authority, admonished Ms. Bouvia because "there is hope in life" and because she could be a "symbol of hope" to others similarly situated.⁹⁵³ The court believed that she could live another fifteen to twenty years.⁹⁵⁴

Although recognizing her decision as rational and competent,⁹⁵⁵ the court concluded that allowing her request would have "a profound effect on the medical staff, nurses and administration" of her treating hospital.⁹⁵⁶ Furthermore, the motive behind the anticipated act and the actual act itself of starvation would constitute suicide, thereby violating the state's interest in preserving life and preventing the assistance of life being taken.⁹⁵⁷ One commentator suggests that the court discriminated against Ms. Bouvia because she was prevented from exercising an ability to achieve an act (e.g., starvation) which an equally competent person who is not physically incapable could do without restriction.⁹⁵⁸

In the case of a young woman, such as Ms. Bouvia, who openly contemplates her suicide, surely reasonable efforts should be made not only to assess her competency but also to dissuade her from self-destruction. The testing area is what happens after reasonable steps fail. Perhaps, after a waiting period of six months during which a psychiatric assessment and psychological counseling may be given, a re-evaluation of an initial request for starvation could be made.⁹⁵⁹ Because Ms. Bouvia had been previously hospitalized for several days in order to "change her mind,"⁹⁶⁰ it is perhaps possible that further hospitalization and forced feeding would allow her to once again change her mind.⁹⁶¹ Although forced feeding of a competent adult raises serious issues of individual autonomy and integrity, efforts to persuade and *offer* oral

⁹⁵⁰ *Id.* at 489.

⁹⁵¹ *Id.* at 491.

⁹⁵² *Id.*

⁹⁵³ *Id.*

⁹⁵⁴ *Id.* at 489.

⁹⁵⁵ *Id.* at 487.

⁹⁵⁶ *Id.* at 488.

⁹⁵⁷ *Id.* at 490.

⁹⁵⁸ See Van den Haag, *A Right to Die?*, NAT'L REV., May 9, 1984, at 45, 46.

⁹⁵⁹ See Annas, *When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia*, HASTINGS CENTER REP., Apr. 1984, at 20, 21.

⁹⁶⁰ *Id.* at 46.

⁹⁶¹ See *id.*

nutrition should perhaps continue.⁹⁶² But beyond these actions set within a defined time frame, it would appear brutal and unconscionable to require more than this.⁹⁶³

By the time her appeal was decided April 16, 1986, Ms. Bouvia, now twenty-eight years of age, had regrettably deteriorated to such an extent that her palsy and quadriplegia were now joined with a degenerative and very crippling type of arthritis.⁹⁶⁴ She was completely bed-ridden and, with the exception of slight head and facial movements, was physically helpless and dependent upon the care of others.⁹⁶⁵ She had to lay flat on her back for the remainder of her life, continually suffering pain.⁹⁶⁶ In addition to tubal liquid feeding, she had another tube attached permanently to her chest that injected her periodically with morphine in order to relieve some of her pain.⁹⁶⁷ The court granted Ms. Bouvia's request for preliminary injunction and ordered the removal of her nasogastric tube and prohibited its further use.⁹⁶⁸ Additionally, any replacement tube or any such device like it could not be given without her request.⁹⁶⁹

Noting the factual similarity of Ms. Bouvia's condition to William Bartling,⁹⁷⁰ and the similarity of issues to *Barber*,⁹⁷¹ the court held that a patient may refuse any medical treatment or medical service even though such treatment or service may be termed nourishment and hydration, and even if such actions precipitate a life-threatening condition.⁹⁷² Observing that Ms. Bouvia was neither comatose, vegetative, nor in a terminal condition,⁹⁷³ the court also recognized that the quality of her existence had become hopeless, useless, unenjoyable and

⁹⁶² See *id.*

⁹⁶³ See *id.* See generally Note, *The Role of Law in Suicide Prevention: Beyond Civil Commitment — A Bystander Duty to Report Suicide Threats?*, 39 STAN. L. REV. 929 (1987).

⁹⁶⁴ *Bouvia*, 179 Cal. App. 3d at 1135-36, 225 Cal. Rptr. at 299-300; see also Annas, *Elizabeth Bouvia: Whose Space Is It Anyway?*, HASTINGS CENTER REP., Apr. 1986, at 24; Williams, *The Right to Die*, 134 NEW L.J. 73 (1984).

⁹⁶⁵ *Bouvia*, 179 Cal. App. 3d at 1136, 225 Cal. Rptr. at 300.

⁹⁶⁶ *Id.*

⁹⁶⁷ *Id.*

⁹⁶⁸ *Id.* at 1146, 225 Cal. Rptr. at 307.

⁹⁶⁹ *Id.*

⁹⁷⁰ *Id.* at 1138, 225 Cal. Rptr. at 301-02 (citing *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984)).

⁹⁷¹ *Id.* (citing *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)).

⁹⁷² *Id.* at 1137, 225 Cal. Rptr. at 300.

⁹⁷³ *Id.* at 1142-43, 225 Cal. Rptr. at 304.

frustrating.⁹⁷⁴

The court determined that the right of refusal derives from not only the right of privacy protected by the state and federal constitutions, but by case precedent — *Bartling* and *Barber*, specifically — and by the California Natural Death Act.⁹⁷⁵ Furthermore, the decision to forego mechanical treatment was solely within Ms. Bouvia's own province to determine.⁹⁷⁶

It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's alone.⁹⁷⁷

With respect to motive, the court determined that if a right is recognized, the motivation behind its exercise is irrelevant.⁹⁷⁸ Thus, the right may be exercised without the approval of any other person.⁹⁷⁹ Moreover, the right to refuse treatment may not be characterized as suicide or an assistance of it.⁹⁸⁰ Citing California case precedents to support its findings,⁹⁸¹ the court observed that the means to effect or assist a suicide traditionally involved conduct that was affirmative in nature, proximate or direct such as furnishing a gun or poison.⁹⁸² "Here all that is being considered is the presence of a doctor directing the exercise of a constitutional right."⁹⁸³

Prior to March 22, 1983, Paul Brophy had been a healthy and robust forty-nine-year-old emergency medical technician and fireman in Easton, Massachusetts.⁹⁸⁴ On the evening of the twenty-second, he suf-

⁹⁷⁴ *Id.* at 1142, 225 Cal. Rptr. at 304.

⁹⁷⁵ *Id.* at 1139-40, 225 Cal. Rptr. at 302-03.

⁹⁷⁶ *Id.* at 1143, 225 Cal. Rptr. at 305.

⁹⁷⁷ *Id.*

⁹⁷⁸ *Id.* at 1145, 225 Cal. Rptr. at 306.

⁹⁷⁹ *Id.*

⁹⁸⁰ *Id.*

⁹⁸¹ *In re Joseph G.*, 34 Cal. 2d 429, 667 P.2d 1176, 194 Cal. Rptr. 163 (1983).

⁹⁸² *Bouvia*, 179 Cal. App. 3d at 1145, 225 Cal. Rptr. at 306.

⁹⁸³ *Id.* (citing *Joseph G.*, 34 Cal. 2d 429, 667 P.2d 1176, 194 Cal. Rptr. 163 (1983)).

In *In re Requena*, 213 N.J. Super. 443, 517 A.2d 869 (1986), the court compelled St. Clare's Riverside Medical Center, a Catholic-affiliated hospital, to allow petitioner, dying of amyotrophic lateral sclerosis ("Lou Gehrig's Disease"), to remain as a patient. *Id.* In addition, the court compelled the hospital to co-operate with her refusal of tubal feeding. *Id.* The court compelled the hospital in these orders despite a contrary institutional policy against such procedures and the availability of another facility for her transfer. *Id.* The court maintained that hospital staff sensibilities were subordinate to the psychological pain and trauma the patient would suffer if transferred. *Id.*

⁹⁸⁴ *Brophy v. New Eng. Sinai Hosp., Inc.*, 398 Mass. 417, 421, 497 N.E.2d 626, 628

ferred the rupture of an aneurysm at the apex of his basilar artery.⁹⁸⁵ Although not considered brain dead, he failed to regain consciousness and became vegetative.⁹⁸⁶ He was kept alive by the maintenance of a surgically inserted device, or gastrostomy tube (G-tube) through which he received nutrition and hydration.⁹⁸⁷ When the hospital refused to respect the family's decision to remove Mr. Brophy's feeding tube, Mrs. Brophy sought legal redress.⁹⁸⁸ While acknowledging that Mr. Brophy could decline the use of the G-tube if he were competent, the trial court nonetheless refused to permit removal, arguing that the state's interest in preserving life outweighed his right to choose his form of treatment.⁹⁸⁹ On expedited appeal, the Massachusetts High Court held that the personal rights of self-determination and individual autonomy arising from the common law and the constitutional right to privacy gave Mr. Brophy's surrogate decision maker the right to refuse medical treatment.⁹⁹⁰ The court further noted that this right was superior to that of the state interest in preserving life.⁹⁹¹

Drawing upon past precedents,⁹⁹² the court concluded that when efforts to sustain life were demeaning or degrading to one's humanity, an individual had every right to avoid such circumstances.⁹⁹³ The court acknowledged that while the distinction between ordinary and extraordinary care was a factor of some meritorious consideration, its use should not be the primary factor in decision making.⁹⁹⁴ The court stated: "[T]o state that the maintenance of nutrition and hydration by the use of the existing G-tube is only ordinary is to ignore the total circumstances of Brophy's situation. He cannot swallow. . . . [T]o be maintained by such artificial means over an extended period is not only intrusive but extraordinary."⁹⁹⁵

(1986).

⁹⁸⁵ *Id.*

⁹⁸⁶ *Id.*

⁹⁸⁷ *Id.*

⁹⁸⁸ *Id.* at 422, 497 N.E.2d at 627.

⁹⁸⁹ *Id.* at 422 n.5, 497 N.E.2d at 627 n.5.

⁹⁹⁰ *Id.* at 430, 497 N.E.2d at 635.

⁹⁹¹ *Id.* at 439, 497 N.E.2d at 644.

⁹⁹² See, e.g., *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *In re Spring*, 380 Mass. 255, 405 N.E.2d 115 (1979); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

⁹⁹³ *Brophy*, 398 Mass. at 432-34, 497 N.E.2d at 634-35.

⁹⁹⁴ *Id.* at 437, 497 N.E.2d at 637.

⁹⁹⁵ *Id.* The trial court accepted evidence indicating that the longest recorded survival by such means was thirty-seven years. *Id.*

In response to the hospital's argument, the Massachusetts High Court agreed that the hospital was not obligated to deny nutrition and hydration to facilitate Mr. Brophy's death, and that the moral and ethical principles of the medical profession forbade such practices.⁹⁹⁶ The court found that neither the doctrine of informed consent, the Massachusetts Patients Right Statute "nor any other provision of law requires the hospital to cease hydration and nutrition upon request of the guardian."⁹⁹⁷ Acknowledging that *Saikewicz*⁹⁹⁸ and its "progeny" would not compel health care providers to undertake measures that would be regarded as contrary to their views, the court concluded that the right of a patient to refuse medical treatment "does not warrant such an unnecessary intrusion upon the hospital's ethical integrity in this case."⁹⁹⁹ Thus, the solution to this quandary is to order the Mount Sinai hospital to "assist" in transferring Mr. Brophy to a suitable facility where his primary wishes may be effectuated.¹⁰⁰⁰

Since *Brophy* is the first written state supreme court opinion authorizing the removal of artificial, tubal feeding during the patient's present existence, it should be viewed as quite significant. The court took a bold step in finding that a feeding tube may be intrusive, extraordinary treatment.¹⁰⁰¹ The court noted that when a feeding tube is removed from a persistently vegetative patient, the cause of death should be understood as the underlying condition preventing swallowing, not the removal of the tube.¹⁰⁰²

Brophy's significance goes even farther in re-enforcing a developing judicial trend that acknowledges the right of a patient to refuse artificial feeding as she would all other medical treatments.¹⁰⁰³ The decision

⁹⁹⁶ *Id.* at 440, 497 N.E.2d at 639.

⁹⁹⁷ *Id.*

⁹⁹⁸ *Id.* (citing Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)).

⁹⁹⁹ *Id.*

¹⁰⁰⁰ *Id.* at 434-35, 497 N.E.2d at 639-40.

¹⁰⁰¹ *Id.* at 432, 497 N.E.2d at 636.

¹⁰⁰² *Id.* at 432-33, 497 N.E.2d at 637-38.

¹⁰⁰³ *See id.*; see also Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986). On December 10, 1987, the Washington State Supreme Court held that a 22 year old woman suffering from Batten's disease (a terminal genetic, neurological condition) — though *not* comatose but suffering from severe and permanent mental deterioration — has a right under Washington law to have life-sustaining treatment withheld. *In re Grant*, 56 U.S.L.W. 2341 (Wash. Dec. 22, 1987). In *Grant*, the patient requested to have nasogastric tubes and intravenous feeding withheld at her mother's request. *Id.* However, Missouri has refused to join the trend in recognizing a patient's right to die. In *Cruzan v. Harmon*, 57 U.S.L.W. 2324 (Mo. Dec. 6, 1988), the

refuses to recognize any valid moral distinction between withholding treatment and withdrawing treatment; a refusal of life-sustaining treatment is not synonymous with suicide, it is inapplicable.¹⁰⁰⁴ An incompetent patient's substituted judgment outweighs the state's interest in preserving life even though she is not diagnosed as terminal. In light of the far-reaching effect of this notable trend, state legislatures should be cautioned against enacting legislation that would seek to prohibit artificial feeding.¹⁰⁰⁵

4. The Aftermath

Quinlan, Saikewicz, Dinnerstein, Spring, Barber, Bartling, Conroy, Brophy, Jobs, and Bouvia all point with unremitting clarity to the fact that more and more courts are respecting acts of enlightened self-determination by competent patients — or their surrogate decision makers — to withhold or withdraw life-sustaining medical treatments, even though death may result.¹⁰⁰⁶ Behind the extended judicial rhetoric of balancing individual privacy interests and rights of self-determination against countervailing state interests¹⁰⁰⁷ is a highly predictable endpoint of judicial reasoning;¹⁰⁰⁸ once it is reasonably understood that one has chosen to end her life by refusing life-sustaining medical treatment, the appellate courts will respect and uphold this decision as within her common-law right of self-determination as guaranteed by the right of privacy found within the Fourteenth Amendment to the Constitution.¹⁰⁰⁹

Missouri Supreme Court held that when an incompetent is neither legally dead nor terminally ill, even if there is no hope of recovery, a legal guardian may not seek judicial assistance in removing the patient's feeding tubes. *Id.*

¹⁰⁰⁴ *Brophy* particularly held that refusing medical treatment merely allows the particular disease to take its natural course, and when death eventually occurs, it is primarily from the underlying disease and not from the self-inflicted injuries. *Brophy*, 398 Mass. at 434, 497 N.E.2d at 638; see also *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987).

¹⁰⁰⁵ See Annas, *supra* note 665, at 26; Gostin, *A Right to Choose Death: The Judicial Trilogy of Brophy, Bouvia, and Conroy*, 14 LAW, SCI. & MED. 198 (1986); see also Reidinger, *Trends in the Law: Go Gentle into That Good Night — More States Recognize Right to Die*, 74 A.B.A. J. 122 (1988).

¹⁰⁰⁶ See Gostin, *supra* note 1005.

¹⁰⁰⁷ See *In re Conroy*, 98 N.J. 321, 343, 486 A.2d 1209, 1223 (1986).

¹⁰⁰⁸ See Gostin, *supra* note 1005, at 198.

¹⁰⁰⁹ *Id.*; see also Annas, *Fashion and Freedom: When Artificial Feeding Should Be Withdrawn*, 75 AM. J. PUB. HEALTH 685 (1985). In what appears to be the first federal court decision directly addressing the right to die issue, the Federal District Court of Rhode Island ruled that the right of privacy implicit in the fourteenth amend-

V. A CONSTRUCT FOR DECISION MAKING OR THE FRAMEWORK FOR PRINCIPLED DECISION MAKING

A. *The Structural Goals and Procedures*

Because of the great variation in the factual situations of each case of critical and terminal illness, no one approach or procedural scheme is either possible or desirable. The individual situation gives rise to and mandates a functional or situational ethic of response.¹⁰¹⁰ Yet, certain goals can be set. An advance directive requesting treatment should be executed to serve as an obvious guide for subsequent cases. However, when it becomes necessary or operative, the management of a patient's actual case must be made in light of all current circumstances which may not have been foreseen by the patient when making her original directive.¹⁰¹¹ When all concerned parties cannot agree on an acceptable medical alternative, a compromise should be sought.¹⁰¹² If an institutional ethics committee exists, the compromise should be worked out there.¹⁰¹³ If the committee is unable to find a consensus solution or compromise, and disagreement continues between at least two of either the health care professionals, or members of the family, then legal redress should be sought in the courts.¹⁰¹⁴

It is strongly urged that the courts avoid making decisions among several treating options. Instead, courts should appoint a responsible surrogate decision maker or guardian to collect and consider all information relevant to making a decision regarding the course of treatment. Any decision would be reported to the court.¹⁰¹⁵ In the long run, justice would be promoted in each case if the duly appointed surrogate is given wide discretion in her decision-making authority. Legislatures and courts should never look to the judicial process for making routine decisions.¹⁰¹⁶ Expeditious and sensitive decision making is more obtainable

ment's due process clause includes the right to decline life sustaining treatment in the form of nourishment and hydration. *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988).

¹⁰¹⁰ See PRESIDENT'S COMMISSION, *supra* note 386, at 192.

¹⁰¹¹ See *id.* at 193.

¹⁰¹² *Id.*

¹⁰¹³ See *id.* at 194.

¹⁰¹⁴ See *id.* at 154, 194.

¹⁰¹⁵ See *id.*

¹⁰¹⁶ See *id.* at 156, 196. Overusing courts for these issues appears to have its counterpart in the medical professions tendency to overtreat. See Newman, *Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for The Family, The Physician and The State*, 3 N.Y.L. SCH. HUM. RTS. ANN. 35, 79 (1985).

In Judge Jones' dissent in *In re Storar*, 52 N.Y.2d 363, 386, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 278 (1981) (Jones, J., dissenting), he stressed that there was "no empir-

through intra-institutional processes than protracted judicial inquiry.¹⁰¹⁷ Ethical and social policy can also more easily take form through the deliberative processes of committee work, which would in turn benefit future similarly related cases.¹⁰¹⁸ The well-being of the patient remains the focus and primary goal of all decision making for the incapacitated.¹⁰¹⁹ For the competent, any decision must recognize the patient's right to pursue rational and self-enlightening acts of autonomy.

B. The Family

The extent of the family's right to direct or interfere with treatment decisions of the competent or incompetent terminally ill *or* nonterminal family member remains an unsettled area of contention. The family's right to assert the patient's right to self-determination in the areas of tragic choice cannot remain unfettered and unchallenged. However, intrusions by the state or primary health care providers should be limited generally to those cases in which the limits of reason and the best interests of the incapacitated family member are being disregarded in a flagrant manner.¹⁰²⁰

In expanding upon the circumstances when a family member should not be regarded as having sole decision-making authority over issues of withholding or withdrawing life-sustaining treatments, three situations can be submitted when intrusion or challenge must be made: (1) when the parent or other family member is unable to comprehend the relevant medical facts of the instant case; (2) when they are emotionally unstable and; (3) when they appear to be placing their own interests before those of the severely handicapped or at-risk family member.¹⁰²¹ Indeed, physicians often make a much better surrogate decision maker than a parent or other family member. Physicians may exercise a greater objectivity, technical knowledge, and expertise given their professional involvement with similarly patterned illnesses and their knowledge of complex health problems.¹⁰²²

ical evidence that society or its individual members have suffered significantly in consequence of the absence of judicial oversight." *Id.*

¹⁰¹⁷ See PRESIDENT'S COMMISSION, *supra* note 386, at 169.

¹⁰¹⁸ See *id.* at 161.

¹⁰¹⁹ *Id.* at 170.

¹⁰²⁰ See McCormick, *supra* note 350, at 339, 378. See generally Smith, *Defective Newborns and Government Intermeddling*, 25 MED. SCI. & L. 44 (1985).

¹⁰²¹ See R. WEIR, SELECTIVE NONTREATMENT OF HANDICAPPED NEWBORNS 269 (1984).

¹⁰²² See *id.*

Once a decision is made to provide life-sustaining treatment for a seriously ill patient, the issue of the costs of the continuing care come into focus.¹⁰²³ Families need programs that can support their valiant efforts, especially when special care is required either at home or in an institution.¹⁰²⁴ Hospice care is becoming a more viable option for the last stages of a terminal illness; specialized care can be given within a family-like setting without the physical and economic drain of at-home care.¹⁰²⁵

C. Reasonableness

Social justice demands that each individual should be given an equal opportunity to maximize her individual potential. Yet, individuals often reach a point in their lives when their maintenance is a defiance of both humanitarianism and social justice. When an individual's condition represents a negation of "truly human" qualities or of "relational potential," the best form of treatment should be no treatment at all.¹⁰²⁶ Stated otherwise, when therapies would be futile, and thus run counter to the best interests of a patient, they should not be undertaken regardless of the age of the patient.¹⁰²⁷ In this instance, efficacious treatment is no treatment at all. Although the potentiality for human relationships cannot be measured with absolute precision, in the cases for example of an anencephalic infant born without a brain, or of a patient who has been declared brain dead, it is rather obvious that these individuals would not qualify for developing the potentiality.¹⁰²⁸

In less clearly defined cases, the standard of reasonableness, which is always flexible and responsive to individual factual applications, may offer a useful if not dominant construct for decision making. Any decision based on reasonableness must balance specific social policies emerging from each particular case against principles of justice, humaneness, or love.¹⁰²⁹ The best interests of one family member would necessarily be based upon individual family beliefs in a set of social,

¹⁰²³ See PRESIDENT'S COMMISSION, *supra* note 386, at 228.

¹⁰²⁴ See *id.*

¹⁰²⁵ See S. LACK & R. BUCKINGHAM, *FIRST AMERICAN HOSPICE* (1978); S. STODARD, *THE HOSPICE MOVEMENT* (1978); Note, *Hospice: The Legal Ramifications of a Place to Die*, 56 IND. L.J. 673 (1981).

¹⁰²⁶ See McCormick, *supra* note 350, at 349.

¹⁰²⁷ See PRESIDENT'S COMMISSION, *supra* note 386, at 6.

¹⁰²⁸ See generally Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, HASTINGS CENTER REP., Nov. 1972, at 1.

¹⁰²⁹ See Fletcher, *Love is the Only Measure*, 83 COMMONWEALTH 427 (1966).

spiritual, and economic values. If an act renders more harm than good to the at-risk individual and to those around her, the act would properly be viewed as unloving, unjust, or inhumane. Thus, the concepts of ordinary and extraordinary treatment are little more than value judgments that determine whether a given course of treatment poses an undue hardship on the patient or provides some hope for a direct benefit.¹⁰³⁰

The crucial point to understand is that the linchpin to deciding in a constant state of pain any course of reasonable action is a basic cost/benefit analysis. Its stated simplicity belies its complexity in application; reasonableness will always be incapable of absolute predetermination. In other words, the application of this cost/benefit analysis will always be set in motion and constrained by the dynamics of each specific case and by the accepted standards of medical science and practice.

D. Intra-Institutional Review

Hospital ethics committees are immensely valuable as a construct for decision making. Yet, it would not be cost-effective to convene the committee for every difficult ethical problem. Committee involvement should occur only when the ethical deliberations reveal an exceedingly complex question.¹⁰³¹

A prognosis committee is potentially more crucial to validating decisions which either withhold or withdraw life-sustaining treatment than an ethics committee. If this committee reaches a unanimous decision, the work of any other committee is greatly minimized. Thus, when a disagreement arises between a personal physician and the family over the prognosis for an at-risk patient family member or between a court-appointed guardian, the matter should be referred to the treating institution's prognosis committee for a second opinion. This committee would be assembled on an *ad hoc* basis, as need arises, and would be composed of the patient's physician and at least two other staff physicians. If the committee unanimously agrees that the patient will never return to a rational or functioning state, then the prognosis would be

¹⁰³⁰ See R. McCORMICK, NOTES ON MORAL THEOLOGY 1965 THROUGH 1980, at 565 (1981). See generally G. SMITH, *supra* note 31, at 2, 8, 164; Arras, *Toward an Ethic of Ambiguity*, HASTINGS CENTER REP., Apr. 1984, at 25.

¹⁰³¹ See Purtilo, *Ethics Consultations in the Hospital*, 311 NEW ENG. J. MED. 983, 984 (1984). See generally Otten, *Can't We Put My Mother to Sleep*, WALL ST. J., June 5, 1985, at 30, col. 3. One author has cautioned that ethics committees need a proven performance record in these areas before they should be endorsed widely or required by the courts. Newman, *supra* note 1016, at 80-81.

entered in the patient's medical record.¹⁰³²

Essentially, the only function of a prognosis committee would be to confirm the diagnosis and the prognosis. This committee would have the ultimate responsibility in determining whether there was any reasonable hope for recovery for the terminally ill patient.¹⁰³³ If the prognosis committee could not resolve the matter, the matter would be sent to a full multidisciplinary ethics committee for resolution. Even if the ethics review committee were to review the case after the case had received a unanimous opinion from the prognosis committee, it is hoped that the thorough and professional "preliminary" work of the prognosis committee would considerably lighten the work of the ethical reconsideration.

Perhaps the easiest way to avoid the cumbersome machinery of committee decision making would be to relieve the physician of civil and criminal liability for those actions which she might undertake in *good faith*.¹⁰³⁴ This standard of reasonableness, or good faith, is a well tested and proven mechanism for assessing degrees of responsibility within the law. However, if the physician followed the course of action suggested by this proposal, the current disjointed state of legal, social, and medical attitudes would most surely subject the physician to professional censure as well as civil and criminal liability. The directions are clear from a handful of cases and from a significant legislative trend among the states that terminating actions may be rendered by a physician acting in good faith *if* certain defined procedures are followed. Swift pre-emptory, good faith actions of a unilateral order, which lack an historical or evidentiary record of deliberation and consultation, have yet to be approved. Perhaps because of this state of affairs in the United States, the Dutch physicians who regularly assist terminally ill patients with acts of enlightened self-determination regularly employ a "team" of doctors, nurses and a representative of the patient's faith to counsel and evaluate the requests for relief made by terminally ill patients. These teams also provide a level of protection and cover for the doctor's legal liability if she were ever to be prosecuted.¹⁰³⁵ This team has an obvious parallel in the prognosis committee, or ethical review committee used in

¹⁰³² See *In re Colyer*, 99 Wash. 2d 114, 134-35, 660 P.2d 738, 749-50 (1983).

¹⁰³³ See *id.* at 135, 660 P.2d at 750.

¹⁰³⁴ See G. WILLIAMS, *supra* note 38, at 340; see also Newman, *supra* note 1016, at 87 (similarly extending proposal to good faith actions taken by family members). Newman also admonishes courts and legislatures to de-criminalize this sphere of decision making. See *id.*

¹⁰³⁵ See Appleyard, *The Last Appointment*, *The Times* (London), June 7, 1987, at 13, col. 4 (Sunday ed.).

the United States. Of course, the similarity in this procedural mechanism between Holland and the United States is the only aspect of sharing; Holland regards the right of enlightened self-determination in an altogether more tolerant and accepting manner than is evident in the United States.

What of the nonterminal yet severely suffering patient who can expect little more than years of suffering, incapacitation and personal degradation because of her Elizabeth Bouvia type of condition? Surely, she should have the same rights of self-determination as other less-afflicted citizens. After a period of psychological counseling, the physically and mentally distressed individual should present her case to an ethical tribunal for the required permission and/or assistance in ending her life.¹⁰³⁶ Composed of a wide sampling of independent individuals, representing legal, ethical, medical, social, religious, and lay interests, the tribunal would be empowered to decide the issue before it without interference or deference to any other interest group. Ideally an *amicus curiae* could oppose the position taken by the petitioner. If the committee rules in favor of the petitioner, then she must be assisted in ending her life. Contrariwise, if the committee rules against the petitioner, the deliberative issue is whether she should involuntarily be committed to a state or other proper institution to prevent her from realizing her goal.

If, after counseling for a reasonable period of time, the individual still wishes to exercise her right of enlightened self-determination, should she be entitled to assistance? In other words, could she ask for another review by the same or different ethics committee or could she appeal to the courts to either assist her actively or passively in exercising her right? One commentator has suggested that before consent is given, the proper authorities should satisfy themselves that it is the "patient's firm and well considered choice and not the desperate whim of a mood of melancholia and not under pressure from others."¹⁰³⁷ However, *Bouvia* suggests that a possible wedge may be developing that would recognize a right of rational self-determination regardless of whether the applicant or petitioner is terminal. Elizabeth Bouvia won the right not to be forced-fed and to starve herself if she wished.¹⁰³⁸ By the court's reasoning, the doctors, who must necessarily assist her in carrying out her wish, are directing the execution of her constitution-

¹⁰³⁶ See generally Dagi, *The Ethical Tribunal in Medicine*, in 1 *ETHICAL, LEGAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD* 201 (G. Smith ed. 1982).

¹⁰³⁷ A. TOYNBEE, *supra* note 46, at 158; see also M. HEIFETZ, *supra* note 35, at 97-98.

¹⁰³⁸ See *supra* notes 950-83 and accompanying text.

ally protected right, not assisting in her demise. If more courts were to see the simple validity of this position, the current state of confusion would end. This view cannot realistically be expected to come quickly; traditional values which seek to preserve "life," regardless of the individual's degenerative state, dictate a response that curtails those who wish to act otherwise and label them as irrational.

E. Legislative and Judicial Responses

Model laws, such as the Uniform Rights of the Terminally Ill and the Uniform Determination of Death Acts, and enactments such as natural death acts, living wills, and durable powers of attorney,¹⁰³⁹ while certainly not an unfettered guarantee of an individual's right to control her final act of self-determination, must be applauded. These laws are constructive both in setting a direction and in responding to a growing number within a contemporary society who demand the option to die with dignity. New laws must be passed to correct the practical difficulties that have been encountered in the administration of these legislative acts.¹⁰⁴⁰

If more enlightened courts of the caliber of *Barber*, *Bartling*, *Bouvia*, and *Brophy* would assert and guarantee the right of every citizen — competent or incompetent, terminal or nonterminal — to refuse life-sustaining treatments and to be assisted in the execution of this right without an imposition of civil or criminal liability, the task of developing a firm judicial construct for decision making may be attained sooner than had been expected.

Always cognizant of their role as interpreters of the law, thus making them reluctant to be bold, creative architects, the courts need strong and unequivocal legislation to assist them in interpreting the law within a framework of contemporary values. This legislation must unerringly recognize an individual's right of autonomy, while protecting the individual from exploitation.¹⁰⁴¹ More specifically, such legislative guarantees should assure that competent patients — or those who not only can appreciate but also understand the nature and consequences of their actions — have an unequivocal right to refuse any form of treatment. Moreover, all citizens should be able to execute a document that not only declares the manner of care they wish to receive should they become incompetent, but also designates a surrogate decision maker to

¹⁰³⁹ See *supra* notes 371-85 and accompanying text.

¹⁰⁴⁰ See generally *id.*

¹⁰⁴¹ See Annas, *supra* note 1009, at 688.

enforce these wishes through a durable power of attorney. Finally, when a patient becomes incompetent and has failed to designate a surrogate decision maker, the patient's legally appointed guardian should be able to direct that any medical treatment be withheld or withdrawn. This course of action should be mandated upon the guardian's demonstration to the immediate health care providers that this action was preferred by the patient. If the patient's wishes are unknown, the guardian could use a cost/benefit analysis to show that the burden imposed by the use of continued treatments "outweighs any reasonably hoped for benefits from the patient's perspective."¹⁰⁴²

F. Other Persuasive Guidelines

The proposals of the New York State Task Force on Life and the Law take another positive step toward shaping a workable construct to aid health care providers, afflicted at-risk patients and surrogate decision makers with complete knowledge of their rights and responsibilities.¹⁰⁴³ The proposals, many of which have been enacted into law, also add a degree of momentum to the growing legislative efforts to acknowledge the right of critically ill patients to assert their right of autonomy.

Opinions by the American Medical Association's Council on Ethical and Judicial Affairs for establishing *Guidelines for Withholding or Withdrawing Life Prolonging Medical Treatment* recognize the ethical propriety for withdrawing life-sustaining medical treatment, including food and water,¹⁰⁴⁴ and afford the physicians and other health care providers with a professional endorsement of actions of this nature.

Protocols, such as the one established by the Massachusetts General Hospital on "Optimum Care for Hopelessly Ill Patients,"¹⁰⁴⁵ also aid in the development of a workable standard of good medical practice in rendering assistance to the terminally ill.

Finally, the framework for principled decision making can be strengthened by a record that discloses few successful legal prosecutions for aiding, abetting, or assisting one in an act of suicidal self-destruction.¹⁰⁴⁶ Moreover, the growing trend is to adhere to the same

¹⁰⁴² *Id.*

¹⁰⁴³ See NEW YORK TASK FORCE REPORT, *supra* note 613.

¹⁰⁴⁴ See Wallis, *supra* note 654, at 60.

¹⁰⁴⁵ *Clinical Care Committee Report*, *supra* note 605, at 362.

¹⁰⁴⁶ See Podgers, *supra* note 34, at 1500-01; *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, *supra* note 34, at 1206; see also Engelhardt & Malloy, *supra* note 34, at 1019-20.

prosecutorial standard of legal inaction for passive euthanasia.¹⁰⁴⁷

Taken as a unit, these various constructs reveal a developing framework for principled medical, legal, ethical, philosophical, religious, and economic decision making. Whether they are recognized for their value or taken as obstructions to the principle of sanctity and preservation of life depends on the attitude of the participants in each particular critical intervention. Perhaps, with time, they will be viewed correctly as keys to humane or reasonable value judgments.

CONCLUSION

It is purely speculative whether the acceptance of a policy of rational suicide will open the floodgate to genocide by eliminating feeble-minded people,¹⁰⁴⁸ or will introduce a bias in favor of death,¹⁰⁴⁹ thereby allowing suicide to be viewed as "socially useful,"¹⁰⁵⁰ or will find a crowd eager to enter the passageway of suicide.¹⁰⁵¹ The fear of the "slippery slope" has accompanied every new release of knowledge, scientific or otherwise.¹⁰⁵² Such fears discount the rationality of humankind and demean their ability to meet and resolve personal crises. Indeed, the humanistic essence and positivism of all religious and theological thinking is also largely discounted by expression of such meddlesome fears.

Perhaps the only permissible restraints — temporal or physical — that can justifiably be placed on a suicidal person are those restraints which lead to either autonomy or rational liberty.¹⁰⁵³ John Stuart Mill, in his essay *On Liberty*, states unequivocally that the only purpose for which power should be exercised over any member of society is to prevent harm to others.¹⁰⁵⁴ Protecting for one's own good, either physical or moral, is not a sufficient warrant for intrusion.¹⁰⁵⁵ Why should not a sane person decide her own fate if the choice is rational and not based

¹⁰⁴⁷ See Podgers, *supra* note 34, at 1500-01.

¹⁰⁴⁸ See *id.* at 1501.

¹⁰⁴⁹ See Blake, *supra* note 244, at 85.

¹⁰⁵⁰ *Id.*

¹⁰⁵¹ See Barber, *Guilty Verdict in Mercy Killing*, USA Today, May 10, 1985, at 3A, col. 1.

¹⁰⁵² See Delgado & Miller, *God, Galileo and Government: Toward Constitutional Protection for Scientific Inquiry*, in 1 ETHICAL, LEGAL AND SOCIAL CHALLENGES TO A BRAVE NEW WORLD, *supra* note 1036, at 231.

¹⁰⁵³ See Fromer, *A Few Good Words for Suicide*, Wash. Post, Sept. 6, 1981, at C5, cols. 1-2.

¹⁰⁵⁴ See Mill, *On Liberty*, in THE SIX GREAT HUMANISTIC ESSAYS OF JOHN STUART MILL 135 (A. Levi ed. 1969).

¹⁰⁵⁵ See *id.*

on impulse or impelled by emotion? Is there some broader societal or moral interest in compelling life for those who would commit suicide?

The judiciary is beginning to elucidate criteria from which a construct for principled decision making may be undertaken. While offering sweeping generalizations, the courts have carefully crafted standards designed for subsequent percental value to provide a developing pathway for the all too many similar case determinations that follow. Although death with dignity may not be acknowledged uniformly as a fundamental right by all states, it is at least being recognized more and more as a humane and enlightened policy.

To bemoan what has been occurring in the courts as a triumph of the functional ethics prescription for death — “death by neglect, dehydration and starvation”¹⁰⁵⁶ for the incurably disabled — and then to conclude dramatically that “the protection afforded life and equality”¹⁰⁵⁷ by the Constitution has been changed for the hopefully suffering and terminally ill,¹⁰⁵⁸ displays an illogical and pro-life blindness that subscribes to the shibboleth that where there is breath, there is “life.” It is also a position that fails *totally* to appreciate or understand the eloquent balancing test of individual costs versus societal benefits used in determining the course of action required in each case of terminal illness. Determining a patient’s best interests are thus grounded in policies of reasonableness and humaneness. It is an inhumane and callous argument that protracts the agony of death by using gastronomy tubes, nasogastric tubes and other means of providing alimentation under the guise of being efficacious treatment.

Suicide. Euthanasia. Rational Suicide. Assisted Rational Suicide. Beneficent Euthanasia. Will these words and theories soon exist only in the past? Hopefully so. What has been proposed could rightly be thought of as being somewhat revolutionary. However, in contemporary times, sometimes revolutions are necessary to correct situations that are seemingly intractable by no other means. Perhaps, if responsive courts and astute state legislatures continue at their current pace, declaring one’s inherent right of enlightened self-determination to determine the nature and form of this last rite of passage, no dramatic revolution in taxonomy will be necessary. Perhaps the revolution will come from *within* the system, thereby giving rise to a new socio-legal-

¹⁰⁵⁶ Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL’Y 71, 121 (1976).

¹⁰⁵⁷ *Id.* at 123.

¹⁰⁵⁸ *Id.*

medical and cultural appreciation of death, which embraces the dying process as humane and nonviolent. This new attitude will recognize old age not as a terminal disease, nor as a stage in the life cycle mandating that all means should be employed to maintain¹⁰⁵⁹ all terminally ill or otherwise incapacitated individuals. If this attitude were adopted, it would then render moot the distinction between the right to decline life-sustaining treatment and the right to commit suicide. This attitude implicitly recognizes that in whatever context of self-determination the central issue is cast, a moral and a legal right is nevertheless bestowed upon the individual to act — for whatever purposes she wishes — to end her life by refusing life-sustaining medical treatment or for whatever enlightened or rational reason she wishes.¹⁰⁶⁰

¹⁰⁵⁹ See Jonas, *supra* note 769, at 31, 34.

¹⁰⁶⁰ See J. CHILDRESS, *supra* note 22, at 163.

